

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00567

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00570

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN MD 22 yrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital								d. STREET ADDRESS R.D. 5			
3. NAME OF DECEASED (Type or print) First Lula				Middle B.				Last Asbury			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1919		9. AGE (In years last birthday) 47 yrs.		10. IF FUNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ----				11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stephen Haynes						14. MOTHER'S MAIDEN NAME Julia Miller					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Lloyd G. Asbury, Elkton, Md. R.D. 5				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u> 420.1 DUE TO (b) <u>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>CORONARY ARTERY DISEASE</u>										INTERVAL BETWEEN ONSET AND DEATH ? 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Rolando A. Najera				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED 1/9/67			
EXAMINER'S NAME (Type) Rolando A. Najera				Address (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1/13/67		23c. NAME OF CEMETERY OR CREMATORY McIntosh Cemetery		23d. LOCATION (City, town or county) (State) Clayhole, Kentucky			
24. FUNERAL DIRECTOR Ralph E. Hicks				ADDRESS Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR JAN 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

08210

00507

00568

CERTIFICATE OF DEATH

00571

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON c. LENGTH OF STAY IN lb 2 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL SINGERLY AVE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHILDS d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eva Middle M. Last Barrow		4. DATE OF DEATH Month January Day 23 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 12, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) RISING SUN, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS RINK		14. MOTHER'S MAIDEN NAME SADIE KEITLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-54-9901	
17. INFORMANT RICHARD BARROW		Address CHILDS, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Uremia DUE TO (b) Urinary Obstruction DUE TO (c) Carcinoma of the pancreas - metastatic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 3 mo.			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Rolando A. Najera, M.D.		22b. DATE SIGNED 1/23/67	
22c. PHYSICIAN'S NAME (Type) Rolando A. Najera, M.D.		22d. ADDRESS 205 E. Main Street, Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/26/1967	23c. NAME OF CEMETERY OR CREMATORY WEST NOTTINGHAM FRIENDS COLORA	23d. LOCATION (City or Town) (County) (State) CECIL MD.
24. FUNERAL DIRECTOR RALPH M. REED		25a. REC'D BY REGISTRAR JAN 25 1967	
ADDRESS RISING SUN, MD.		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00521

STATE OF TEXAS

00522

191

IN SENATE,
January 22, 1911.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1910.
BY
J. M. HARRIS,
COMMISSIONER.
DALLAS: THE TEXAS
PRINTING CO., 1911.

THE TEXAS
PRINTING CO.
DALLAS, TEXAS

00569

CERTIFICATE OF DEATH

00572

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural- Rising Sun Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>P.O. 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>F.</u> Last <u>Bartlett</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11, 1890</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Troyson Co. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Grubb Sr</u>				14. MOTHER'S MAIDEN NAME <u>Frances Nichols</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>R. Emerson Bartlett-Rising Sun, P.O. 2, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Brain tumor operative hemiplegia 1963</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JANUARY</u> , 19 <u>60</u> , to <u>JANUARY</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 29 1967</u> , and that death occurred at <u>12:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>F.B. Robinson M.D.</u>				22b. DATE SIGNED <u>1/30/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Oxford</u>	
22d. ADDRESS <u>133 Locust St. Oxford, Pa.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oxford Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Oxford, Chester, Pa</u>	
24. FUNERAL DIRECTOR <u>RALPH M. REED</u>				25a. REC'D BY REGISTRAR <u>Ralph M. Reed</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

00618

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #0385, 2/20/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02087

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Charlestown</u>	
c. LENGTH OF STAY IN 1b <u>15 yrs.</u>		d. STREET ADDRESS <u>R.D., Carpenters Point</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>V.</u> Last <u>Wolfe Biles</u>		4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1891</u> 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELIAS L. MARTIN</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA ANN HARTING</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Charles Wolpert, R.D., Carpenters Point, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John M. Byens, M.D.</u>		22. DATE SIGNED <u>1-30-67</u> <u>Elkton, Md.</u>	
EXAMINER'S NAME (Type) <u>John M. Byens, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 1, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception Cherry Hill, Cecil Co. Md</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u> <u>Hicks Home for Funerals, Elkton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00570

CERTIFICATE OF DEATH

00573

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun	
c. LENGTH OF STAY IN 1b 1 Year		d. STREET ADDRESS Reynolds Ave	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Dallas Blake		4. DATE OF DEATH Month Day Year Jan 10 19 67	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-1884
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Ret. Ship Yard		11. BIRTHPLACE (County & State, or foreign country) Maryland Balt. Co	
10b. KIND OF BUSINESS OR INDUSTRY Ret. Ship Yard		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. Blake Sr.		14. MOTHER'S MAIDEN NAME Florentine Marriott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 230-18-1445	
17. INFORMANT daughter - Julia Rasmussen		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility - Coronary insufficiency		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 26 , 19 66 , to 9 Jan , 19 67 , that (I) (we) last saw the deceased alive on 9 Jan 67 , and that death occurred at 2 AM , from causes and on the date stated above.			
22a. SIGNATURE Wallace Obenshain		22b. DATE SIGNED 10 Jan 67	
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.		22d. ADDRESS Cecilton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-13-1967	23c. NAME OF CEMETERY OR CREMATORY Zoar Cem.	23d. LOCATION (City or Town) (County) (State) Deltaville Va.
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
25c. ADDRESS Rising Sun, Md.		DATE JAN 12 1967	

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CERTIFICATE OF DEATH

00574

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u> c. LENGTH OF STAY IN 1b <u>1 1/2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>UNION HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL NORTH EAST</u> d. STREET ADDRESS <u>RT. 40</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>BLUMQUIST</u> Last <u>BLUMQUIST</u>		4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-09</u>
9. AGE (in years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>7</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BROOKLYN, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>FRANK MASON</u>		14. MOTHER'S MAIDEN NAME <u>NO INFO.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FREDERICK A. BLUMQUIST</u>		Address <u>NORTH EAST, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion with Myocardial Infarction</u> 7.00.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>21 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>46</u> , to <u>9 Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9 Jan</u> , 19 <u>67</u> , and that death occurred at <u>4:55 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Klaus H. Huebner</u>		22b. DATE SIGNED <u>1/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>KLAUS H. HUEBNER M.D.</u>		22d. ADDRESS <u>NORTH EAST, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BAY VIEW CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>BAY VIEW, MD.</u>
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>259 E. MAIN ST. ELKTON, MD.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 12 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 6 1/2 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS Bouchelle Rd. R.D. 2	
3 NAME OF DECEASED (Type or print) Mary Susan Bouchelle		4 DATE OF DEATH January 14 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887 Sept. 8, 1889
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Cecil Co. Maryland
13. FATHER'S NAME Benjamin Rogers		14. MOTHER'S MAIDEN NAME Mary Susan Cogle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT George R. Bouchelle		Address North East, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Cardiac arrest DUE TO (b) Massive myocardial infarction DUE TO (c) Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Nov. 1963, to Dec. 1967 that (I) (we) last saw the deceased alive on Jan. 4 1967, and that death occurred at 10:30 AM from causes and on the date stated above			
22a. SIGNATURE Jay S. Barnhart Jr.		22b. DATE SIGNED 1/16/67	
22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.		22d. ADDRESS 4 Mauldin Ave. North East, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/17/67	23c. NAME OF CEMETERY OR CREMATORY North East Methodist	23d. LOCATION (City or Town) (County) (State) North East Cecil Co. Md.
24. FUNERAL DIRECTOR Grant Funeral Home		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	

ADDRESS Box 22 North East, Md.

JAN 18 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00573 CERTIFICATE OF DEATH 00576									
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton R.D. 1				
c. LENGTH OF STAY IN 1b Life					d. STREET ADDRESS Blue Ball Rd.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last James Andrew Burns					4. DATE OF DEATH Month Day Year January 4, 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1933		9. AGE (In years last birthday) 33 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Frank Burns					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-10-1662-A		17. INFORMANT Mrs. Mary Wood, Elkton, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, cerebral artery 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Basal cell carcinoma, st. auricle								INTERVAL BETWEEN ONSET AND DEATH 17 d.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12-21-1966, to 1-4-1967, that (I) (we) last saw the deceased alive on 1-4-1967, and that death occurred at 3:40 PM, from the causes and on the date stated above.									
22a. SIGNATURE Tillman D. Johnson M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-5-67		
22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson M.D.					22d. ADDRESS 123 S. 5th Ave. Elkton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/9/67		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City, town or county) (State) Port Deposit, Cecil, Md.			
24. FUNERAL DIRECTOR Ralph E. Hicks ADD					25a. REC'D BY REGISTRAR JAN 13 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00574					00577				
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Elkton			c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital					d. STREET ADDRESS R.D.# 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Oliver			First Middle Last Burns		4. DATE OF DEATH January 15 19 67		Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/12/86		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEELWORKER				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) LANDENBERG, Pa.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Benjamin Burns					14. MOTHER'S MAIDEN NAME William Milson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 186-16-2024		17. INFORMANT MAE B. SICKLER		Address WESTTOWN, PA.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Renal and Hepatic failure DUE TO (c) Diabetic acidosis (coma)								INTERVAL BETWEEN ONSET AND DEATH 1 hr 3 days 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension c/ H.C.V.D.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this/hospital) attended the deceased from 12-22, 1966 , to 1-15, 1967 , that (I) (we) last saw the deceased alive on 1-15-1967 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Louis M. Coza					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) LOUIS M. COZA, M.D.					22d. ADDRESS 322 E. CECIL AVE., NORTH EAST, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 1-18-67		23c. NAME OF CEMETERY OR CREMATORY NEW LONDON PRESBYTERIAN		23d. LOCATION (City, town or county) (State) NEW LONDON PA.		
24. FUNERAL DIRECTOR Robert J. Pippin					25a. REC'D BY REGISTRAR Charles Judge				
25b. REGISTRAR'S SIGNATURE Charles Judge					DATE JAN 18 1967				

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00575					00578				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Cecil MARYLAND					a. STATE Delaware b. COUNTY N.C. ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Elkton						Newark			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Union Hospital					S. Chapel St. R. D. #1				
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH		Month Day Year		
John Campbell					1-19-67		19		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-8-1893		75 yrs.	Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Operator			Fibre		Strickersville, Pa.		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Thomas Campbell					Sarah Ann Squibb				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			221-09-1981		Lettie Campbell		Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary occlusion DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1-18, 1967, to 1-19, 1967, that (I) (we) last saw the deceased alive on 1-19, 1967, and that death occurred at 6:30 AM, from the causes and on the date stated above.									
22a. SIGNATURE Williford Eppes					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-22-67		
22c. PHYSICIAN'S NAME (Type) Williford Eppes					22d. ADDRESS Medical Bldg. Main St. Newark, Dela.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			1-22-67		Ebenezer Cemetery		R. D. # 1 Newark, Dela.		
24. FUNERAL DIRECTOR William J. Warwick					ADDRESS Newark, Dela.		25a. REC'D BY REGISTRAR DATE JAN 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00576					00579				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE				
Cecil MARYLAND					Md. Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural				
c. LENGTH OF STAY IN 1b 2 weeks					d. STREET ADDRESS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hosp.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Troy Harlow Carter					4. DATE OF DEATH Month Day Year Jan 26 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-11-1883		9. AGE (in years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (County & State, or foreign country) Grant Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days	
13. FATHER'S NAME Sanders Carter					14. MOTHER'S MAIDEN NAME Minnie Sebastian				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 213-36-7520				
17. INFORMANT Blaine Carter					Address Rising Sun, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary infarction about 5 minutes 42001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Generalized arteriosclerosis and coronary artery heart disease. unknown (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Probable obstruction of the large bowel.									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan. 12, 1967, to Jan. 26, 1967, that (I) (we) last saw the deceased alive on Jan. 26, 1967, and that death occurred at 8:40 M. from the causes and on the date stated above.									
22a. SIGNATURE S. Ralph Andrews, Jr.					22b. DATE SIGNED 1/26/67				
22c. PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr.					22d. ADDRESS 233 E. Main St., Elkton, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 1-28-1967				
23c. NAME OF CEMETERY OR CREMATORY Freemont Meth. Cem.					23d. LOCATION (City, town or county) (State) Nottingham Pa. R.F.D.				
24. FUNERAL DIRECTOR Gernon E. Mullen					25a. REC'D BY REGISTRAR Rising Sun, Md. JAN 30 1967				
25b. REGISTRAR'S SIGNATURE									

FOR STATE
HEALTH DEPT

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 8 information from birth certificate
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

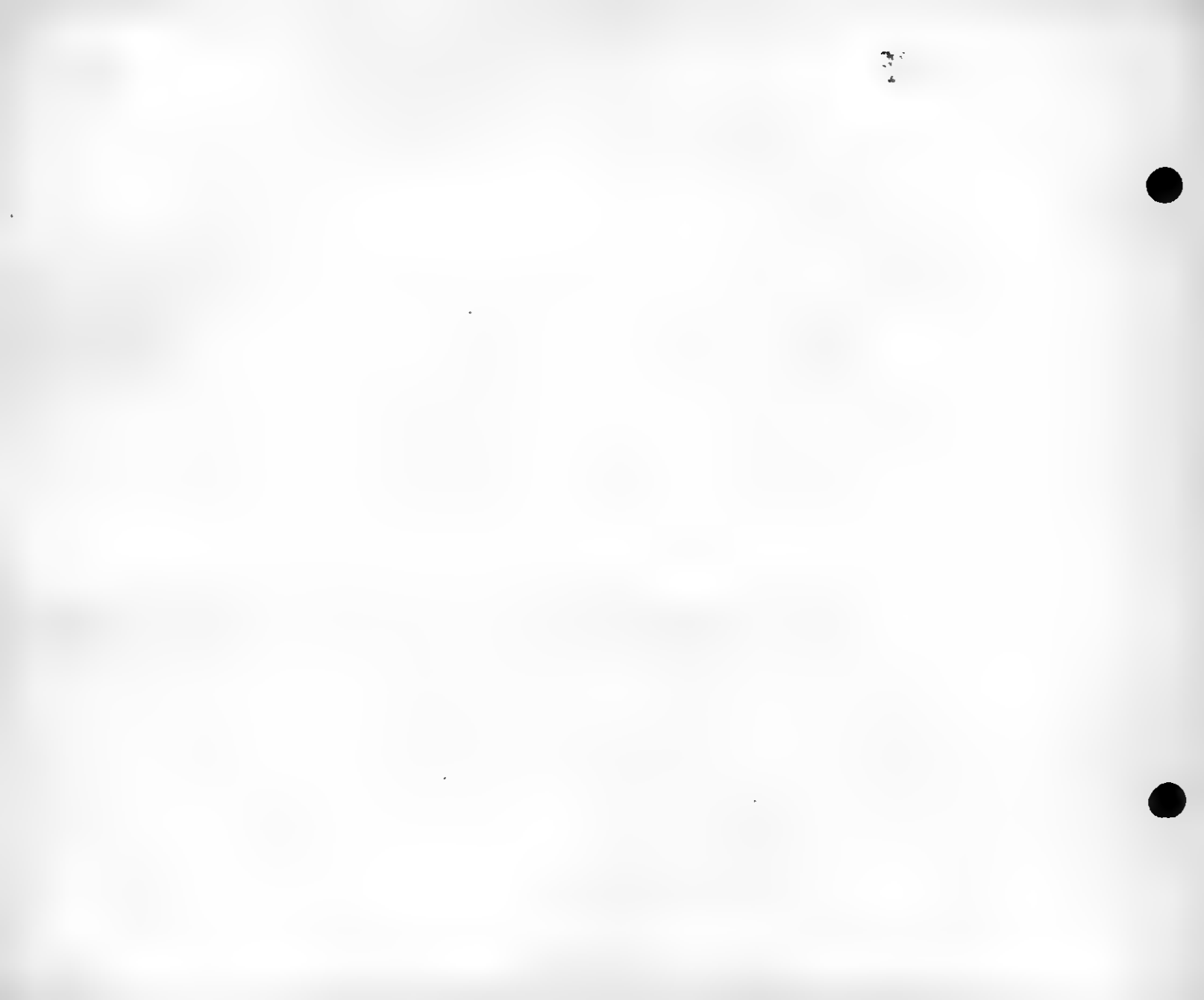
00577

00580

1 PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY in 1b Elk Mills d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elk Mills d. STREET ADDRESS 17-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First WANDA Middle ANN Last CASTEEL		4 DATE OF DEATH Month January Day 31 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 14, 1966
9 AGE (In years last birthday) yrs 1		IF UNDER 1 YEAR Months 1 Days 1 IF UNDER 24 HRS Hours 1 Mn 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Elkton, Md		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James E. Casteel		14 MOTHER'S MAIDEN NAME Jacquelin Dick.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT James E Casteel		Address Elk Mills, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Interstitial pneumonitis SDII DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral catarrhal otitis media		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/2/67	
23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION (City or Town) (County) (State) Elkton Cecil Md	
24 FUNERAL DIRECTOR F. Walter duBois		ADDRESS Elkton Md	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE FEB 3 1967			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1-66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00578

CERTIFICATE OF DEATH

00581

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 5 Yrs.	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perryville		d. STREET ADDRESS Broad Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Broad Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Stella May W. Cochran		4. DATE OF DEATH Month Day Year Jan. 10, 19 67	
5. SEX F	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1898
9. AGE (In years last birthday) 68 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James A. Webb	
14. MOTHER'S MAIDEN NAME Susan Cox		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 229-12-3517		17. INFORMANT Elmer E. Cochran, Perryville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 62 to Jan 10 , 19 67 that (I) (we) last saw the deceased alive on 1-10 19 67 , and that death occurred at 9P M, from causes and on the date stated above.			
22a. SIGNATURE John D. Yun		22b. DATE SIGNED 1/11/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. YUN		22d. ADDRESS HAURE & GRACEY	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-13-1967	
23c. NAME OF CEMETERY OR CREMATORY Laural Fork Cemetery		23d. LOCATION (City or Town) (County) (State) Laural Fork, Va.	
24. FUNERAL DIRECTOR Lee A. Patterson & Son		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JAN 13 1967	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00579

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00582

1. PLACE OF DEATH a COUNTY <i>Cecil</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <i>Md.</i> b COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c LENGTH OF STAY IN 1b <i>4 hrs.</i>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		07.1	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Union Hospital</i>		d. STREET ADDRESS <i>243 E. High Street</i>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <i>James Everett Congo</i>		4. DATE OF DEATH Month <i>1</i> Day <i>5</i> Year <i>1967</i>	
5 SEX <i>M</i>	6 COLOR OR RACE <i>Negro</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>4-28-03</i>
9 AGE (In years last birthday) yrs <i>63</i>		10 IF UNDER 1 YEAR Months <i>63</i> Days <i>63</i> Hours <i>63</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Grave-digger</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mortuary</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13 FATHER'S NAME <i>Harry Congo</i>		14. MOTHER'S MAIDEN NAME <i>Florence Brown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <i>221-05-2167</i>	
17 INFORMANT <i>Mrs. Alverta L. Earl</i>		Address <i>Elkton, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <i>719.5</i> IMMEDIATE CAUSE (a) <i>Shot-gun Wound of Abdomen</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Gun accidentally discharged in getting out of car</i>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Gun accidentally discharged in getting out of car</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>4:57</i> p.m. <i>1-5</i> 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Nor While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>High St., nr. home</i>		20f. (City or town) (County) (State) <i>Elkton Cecil Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John M. Byers, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John M. Byers, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <i>Elkton, Md.</i>	
22. DATE SIGNED <i>1-5-67</i> <i>Elkton, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan 9/1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Griffith Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Cedar Hill, Md.</i>	
24. FUNERAL DIRECTOR <i>Chas. Bell</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
ADDRESS <i>909 Poplar St., Wilmington</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>JAN 9 1967</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00580					00583				
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b Union Hospital d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Earleville. d. STREET ADDRESS 071 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First GRACE Middle V. Last CRAIG			4. DATE OF DEATH Month January Day 24 Year 1967						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 26, 1888	9. AGE (in years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 07	IF UNDER 24 HRS. Days 07	Hours 00	Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home.		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Husfelt.				14. MOTHER'S MAIDEN NAME Hester Gonce.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes give year or dates of service) 217-52-5397		17. INFORMANT Mrs. Mae Davis,		Address Cecilton, Md. 21913			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of left hip intratrochanteric DUE TO (c) Chronic obstructive bronchitis.								INTERVAL BETWEEN ONSET AND DEATH 6 days 14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic obstructive bronchitis.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7 Jan. 1967 to 24 Jan. 1967 that (I) (we) last saw the deceased alive on 24 Jan 67 19 , and that death occurred at 4:00 PM from the causes and on the date stated above.									
22a. SIGNATURE Wallace Obenshain				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 25 Jan 67			
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain. M.D.				22d. ADDRESS Cecilton, Md. 21913					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial.		23b. DATE THEREOF Jan. 26, 1967		23c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery.		23d. LOCATION (City, town or county) (State) Cecilton, Cecil Co; Md.			
24. FUNERAL DIRECTOR Edward Fellows,				ADDRESS Millington, Md. 21651		25a. REC'D BY REGISTRAR JAN 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



00581

CERTIFICATE OF DEATH

00584

1 PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		d. STREET ADDRESS <u>Aiken Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel Lee Craig, Jr.</u>		4. DATE OF DEATH Month Day Year <u>January 15 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Cau</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 19, 1896</u>
9 AGE (n years last birthday) <u>70</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>	
13. FATHER'S NAME <u>Samuel Lee Craig, Sr.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1942-1946</u>		16. SOCIAL SECURITY NO. <u>214-18-1617</u>	
17. INFORMANT <u>Mrs. Mary L. Craig, Perryville, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>480.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Ins. Sclerosis</u> (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>5 days</u> <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Jan 5</u> , 19 <u>67</u> to <u>1-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-13</u> , 19 <u>67</u> , and that death occurred <u>4:14 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. H. Richards, Jr.</u>		22b. DATE SIGNED <u>1-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. H. Richards, Jr.</u>		22d. ADDRESS <u>Port Deposit, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/21/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Principio Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Principio Turnersburg, Md.</u>
24. FUNERAL DIRECTOR <u>Lee & Son, Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 26 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00582

CERTIFICATE OF DEATH

00585

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN <u>LIFE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BLUE BALL ROAD</u>		d. STREET ADDRESS <u>BLUE BALL ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>EFFIE MAY DAVIS</u>		4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-1878</u>
9. AGE (In years past birthday) <u>88</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PENNA. R.R.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CECIL CO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN T. WHIRLOW</u>		14. MOTHER'S MAIDEN NAME <u>RUTH SHEPHERD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>717-07-5684</u>	
17. INFORMANT <u>HARRY H. DAVIS</u>		Address <u>359 W. MAIN ST. ELKTON, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Conduction Dilatation</u> DUE TO <u>4 hrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Chronic Myocarditis</u> DUE TO <u>4 yrs.</u> (c) <u>Arteriosclerosis</u> DUE TO <u>15-18 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>63</u> , to <u>1-26-1967</u> that (I) (we) last saw the deceased alive on <u>1-25-1967</u> , and that death occurred at <u>9:54</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Jacob J. Greenwald</u>		22b. DATE SIGNED <u>1/27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. Jacob J. Greenwald</u>		22d. ADDRESS <u>202 E. Main, St, Elkton, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ELKTON CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>ELKTON CECIL MD.</u>
24. FUNERAL DIRECTOR <u>PAPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>ELKTON, MD</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 30 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00583

CERTIFICATE OF DEATH

00586

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ELKTON</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ELKTON CT.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LEEDS</u>				d. STREET ADDRESS <u>LEEDS</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>A.</u> Last <u>DEAVER SR.</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 14, 1898</u>	9. AGE (In years last birthday) <u>68</u> yrs	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		11. IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGENT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH DEAVER</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>217-01-9507</u>		17. INFORMANT <u>MARGARET W. DEAVER - ELKTON, RR MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>1-3-67</u> IMMEDIATE CAUSE (a) <u>Carcinoma, colon & metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____						INTERVAL BETWEEN ONSET AND DEATH <u>Approx 2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug., 1964</u> , to <u>Jan. 1, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan. 1, 1967</u> , and that death occurred <u>off hours</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>T. L. Johnson</u> M.D.				22b. DATE SIGNED <u>1-3-67</u>		22c. PHYSICIAN'S NAME (Type) <u>T. L. Johnson M.D.</u>	
22d. ADDRESS <u>123 S. 1st St., Elkton, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JAN. 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LEEDS CEMETERY</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <u>LEEDS, CECIL MD.</u>			
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>		ADDRESS <u>ELKTON, MD.</u>		25d. REC'D BY REGISTRAR DATE <u>JAN 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Carlos Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00584

CERTIFICATE OF DEATH

00587

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Cal.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY in 1b 22 days 1 yr 4 mos		d. STREET ADDRESS 7915 Ridgley Oak Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last OLIVER LEROY DESHONG		4. DATE OF DEATH Month Day Year January 20 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-9-95
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITY OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Freemont Deshong		14. MOTHER'S MAIDEN NAME Agnes Melfred Oakman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 163-14-0896	
17. INFORMANT Address VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from Aug. 31, 1965 , to Jan. 20, 1967 , and that death occurred at 12:15 p.m. , from causes and on the date stated above.			
22a. SIGNATURE B. ROTHFELD, M.D.		22b. DATE SIGNED 1-20-67	
22c. PHYSICIAN'S NAME (Type) B. ROTHFELD, M.D.		22d. ADDRESS VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF JAN 23, 67	23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery	23d. LOCATION (City or Town) (County) (State) Harrisville Penna
24. FUNERAL DIRECTOR Eline Funeral Home, Address to., Md.		25a. REC'D BY REGISTRAR DATE JAN 24 1967	
FOR Kelso Funeral Home, McConnellsburg, Penna.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00585					00588				
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md. b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick			c. LENGTH OF STAY IN ID		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First MARY		Middle R.		Last FORBES.		4. DATE OF DEATH Month January Day 12, Year 19 67	
5. SEX Female		6. COLOR OR RACE White.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December, 29, 1892		9. AGE (In years last birthday) 74 IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.				10b. KIND OF BUSINESS OR INDUSTRY Home.		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Mabrey.					14. MOTHER'S MAIDEN NAME Susan Scuse.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. 216-48-5686		17. INFORMANT Stewart W. Forbes, 103 Del. Dr. Collins Park,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. 7-200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 6 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 1, 1966, to 12 Jan, 1967, that (I) (we) last saw the deceased alive on 12 Jan 19 67, and that death occurred at 7:00 PM from the causes and on the date stated above.									
22a. SIGNATURE Wallace Obenshain						22b. DATE SIGNED 13 Jan 67			
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain. M.D.						22d. ADDRESS Cecilton, Md. 21913			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Millington Cemetery.		23d. LOCATION (City, town or county) (State) Millington, Kent Co; Md.			
24. FUNERAL DIRECTOR Edward Fellows,				ADDRESS Millington, Md. 21651		25a. REC'D BY REGISTRAR DATE JAN 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



00586

CERTIFICATE OF DEATH

00589

1 PLACE OF DEATH a COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b. COUNTY Cecil	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c LENGTH OF STAY IN 1b 20 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital of Cecil County		d STREET ADDRESS 278 Hollingsworth Manor	
3 NAME OF DECEASED (Type or print) James F. Gillen		4 DATE OF DEATH January 7 19 67	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/31/15
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant, Va. Perry Point Hosp.		9 AGE (In years last birthday) 51	12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Seaton Gillen		14. MOTHER'S MAIDEN NAME Flora Sheppard	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16 SOCIAL SECURITY NO. 237-12-4291	17 INFORMANT Mrs. Pauline Gillen Address Same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary with Myocardial Infarct- DUE TO ion. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (c) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 1-4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/10/67, 1967 to 1/11/67, 1967, that (I) (we) last saw the deceased alive on 1/10/67, 1967, and that death occurred at 8:10 A.M. from causes and on the date stated above.			
22a. SIGNATURE James L. Johnson		22b. DATE SIGNED Jan. 9, 1967	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 East High St., Elkton, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 1/10/67	23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park, Elkton, Md.	23d. LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR Ralph E. Deeks		25a. REC'D BY REGISTRAR DATE JAN 13 1967	
25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00587					00590				
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY in 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Walnut Lane					d. STREET ADDRESS 303 Elkton Blvd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ann Racine Gillespie			4. DATE OF DEATH Month Day Year January 17, 1967						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1902		9. AGE (In years last birthday) 64 yrs.	10. UNO 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse (R.N.)			10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles David Racine					14. MOTHER'S MAIDEN NAME Harriett R. Holden				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-12-7786		17. INFORMANT Address Irvin P. Racine, Lennox, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery thrombosis 40011 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 87 min Years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan, 1961, to 1-17, 1967, that (I) (we) last saw the deceased alive on 1-17-1967, and that death occurred at 2:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Tillman D. Johnson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-17-67			
22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson M.D.				22d. ADDRESS 123 Singsler Ave Elkton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/20/67		23c. NAME OF CEMETERY OR CREMATORY North East Methodist Cemetery, North East, Md.		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 30 1967		25b. REGISTRAR'S SIGNATURE William Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00588

CERTIFICATE OF DEATH

00591

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>		d. STREET ADDRESS <u>151 E. MAIN</u>	
3. NAME OF DECEASED (Type or print) <u>PEYTON</u> First Middle Last <u>R. HARRISON</u>		4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL SALES</u>	9. AGE (In years last birthday) <u>88</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE CO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>PR. HENRY T. HARRISON</u>		14. MOTHER'S MAIDEN NAME <u>MARION JENIFER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-30-2672</u>	
17. INFORMANT <u>ELBIE C. HARRISON</u>		Address <u>151 E. MAIN ST. ELKTON, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Circulatory Collapse</u> DUE TO (b) <u>Acute pneumonia</u> DUE TO (c) <u>Large bronchial pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>24 hrs.</u> <u>11</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>AND possible large bronchial pneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>66</u> , to <u>1/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> , 19 <u>66</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Peter Stavrakakis</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1/12/67</u>
22c. PHYSICIAN'S NAME (Type) <u>PETER STAVRAKAKIS MD</u>		22d. ADDRESS <u>ELKTON MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEROF <u>1-12-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL</u>	23d. LOCATION (City or Town) (County) (State) <u>TOWSON, MD</u>
24. FUNERAL DIRECTOR <u>Robert Goard</u>		ADDRESS <u>254 E. MAIN</u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>
24. FUNERAL HOME <u>PIPPIN FUNERAL HOME</u>		ELKTON, MD	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

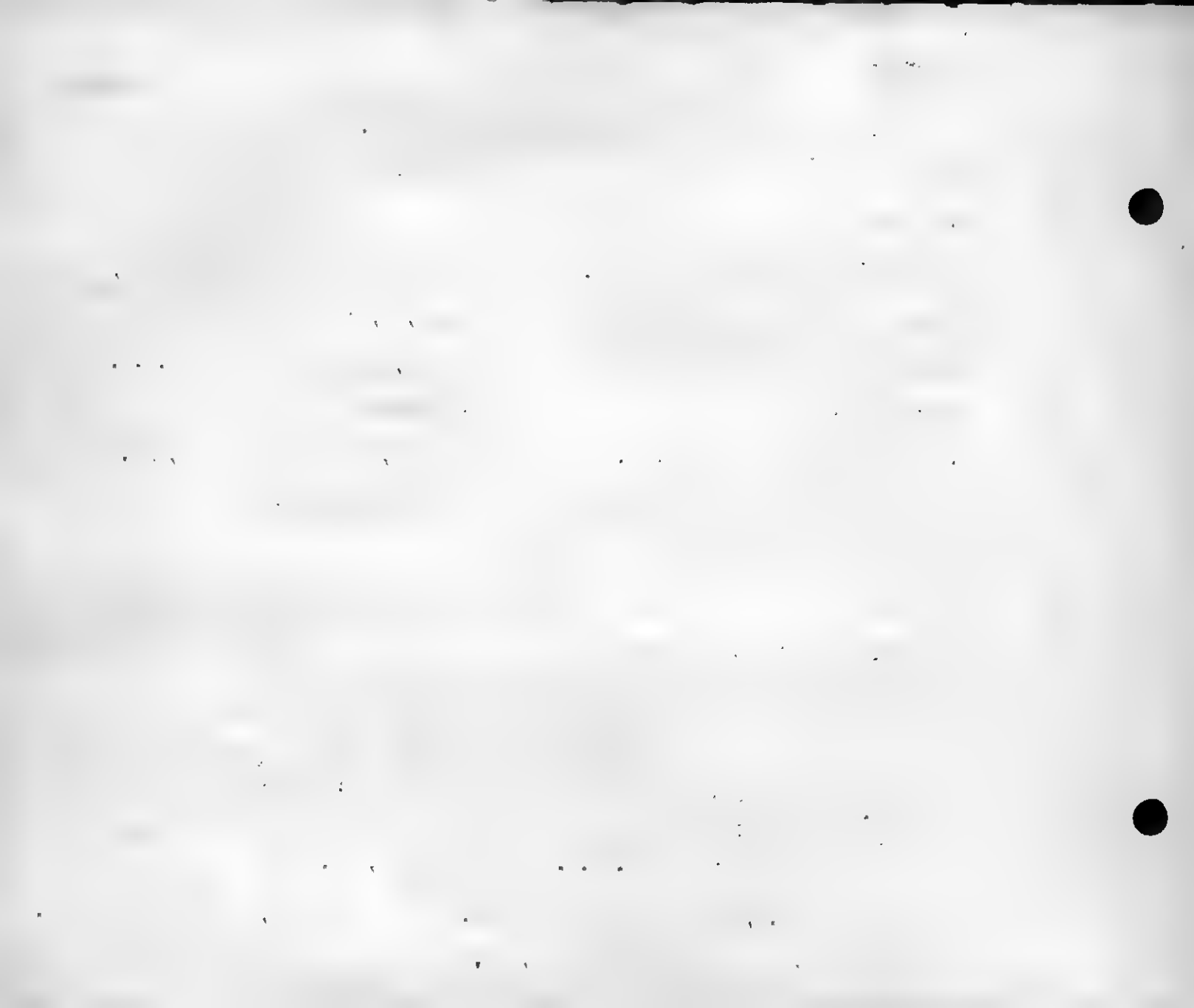
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or other disposal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
00589						00592						
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cecilton				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital						d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print) MAY			First Middle Last B. HINES			4. DATE OF DEATH January 1, 19 67			Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 10, 1893		9. AGE (in years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) London, England			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Plant.						14. MOTHER'S MAIDEN NAME Mary Grogan						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. None.		17. INFORMANT Frank Hines,			Address Cecilton, Md. 21913			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the left kidney 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gram-negative septicemia										INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 12 Dec 1966 to 1 Jan 66, 1967, that (I) (we) last saw the deceased alive on 1 Jan 66 1967, and that death occurred at 12:00 noon from the causes and on the date stated above.												
22a. SIGNATURE Wallace Obenshain						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 1/3/67			
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain. M.D.						22d. ADDRESS Cecilton, Md. 21913						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery.			23d. LOCATION (City, town or county) (State) Galena, Kent Co; Md.					
24. FUNERAL DIRECTOR Edward Fellows,						ADDRESS Millington, Md.			25a. REC'D BY REGISTRAR DATE JAN 5 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A111 (4)
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00590						00593					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
CECIL			ELKTON			MARYLAND			CECIL		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
5 DAYS			UNION HOSPITAL			ELK FOREST			#7 ELK FOREST RD.		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
MOSELLE B. HIRST						JANUARY 11, 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		MARCH 21, 1913		53 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
CLERK				STORE		NORTH CAROLINA				USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
GEORGE BUFFALOE						GOLDIE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
No						WALTER R. HIRST				RD #2 ELKTON, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										2 wks	
IMMEDIATE CAUSE (a) <u>lobar pneumonia</u>											
90X											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?	
Anemia, severe, type undetermined.										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 1-6-1967 to 1-11-1967, that (I) (we) last saw the deceased alive on 1-11-1967, and that death occurred at 3:25 PM, from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
Tillman D. Schusen M.D.									1-13-67		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
Tillman D. Schusen M.D.						123 Sinsler Ave. Elkton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
BURIAL			1/14/67		GILPIN MANOR MEM. PK			ELKTON, MD			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
W.H. PIPPIN FUNERAL HOME						DATE JAN 16 1967			J. Charles Judge		

00591

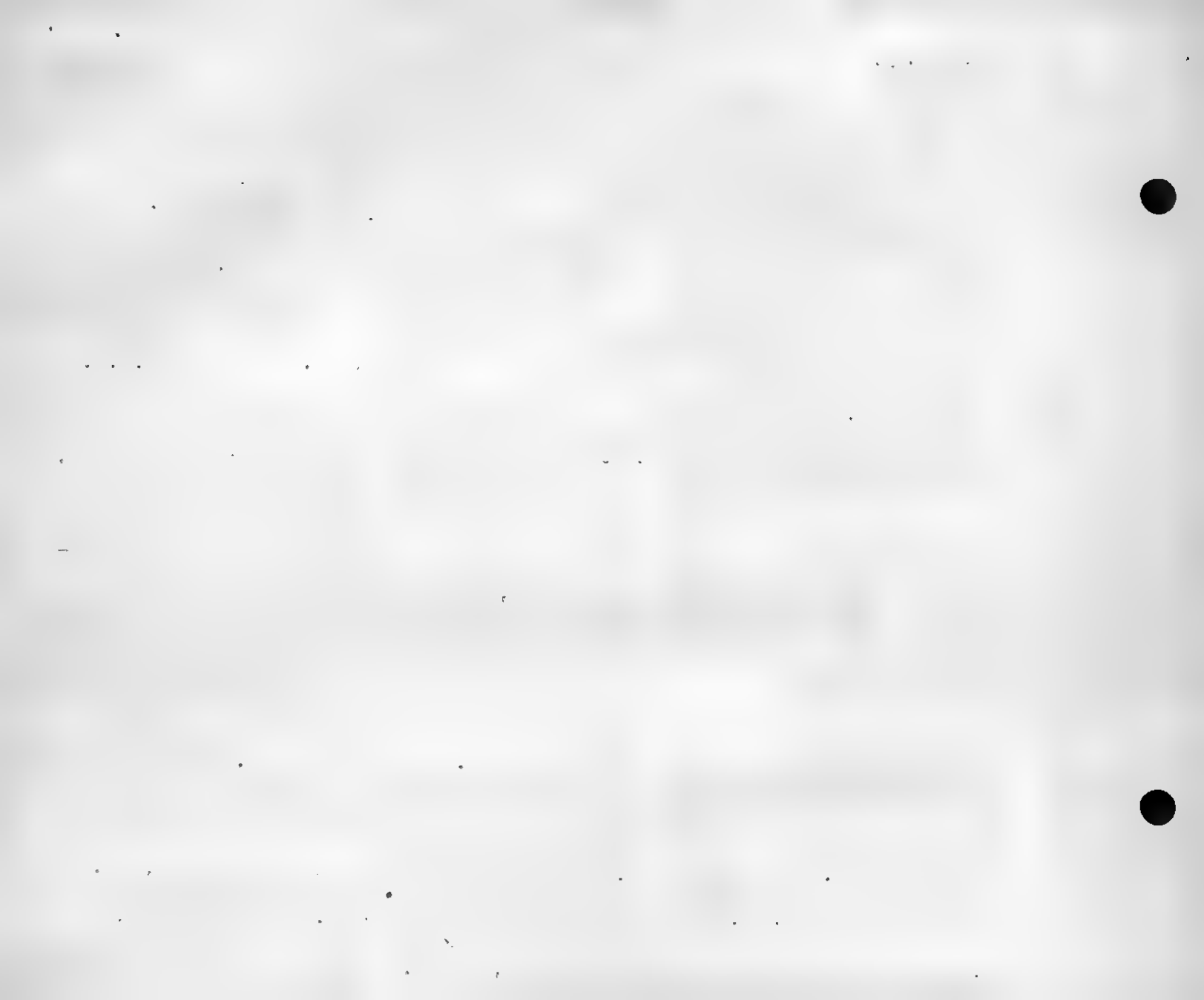
CERTIFICATE OF DEATH

00594

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 3 mos 19 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS 2302 Garrett Ave.	
3 NAME OF DECEASED (Type or print) First Middle Last JOSEPH PETER HUBER		4. DATE OF DEATH Month Day Year January 23 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-6-87
9. AGE (In years lost birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher, retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael L. Huber (D)		14. MOTHER'S MAIDEN NAME Catherine Baker (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 215-07-1861	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized			INTERVAL BETWEEN ONSET AND DEATH 1 1/2-2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that XXXX (this hospital) attended the deceased from Oct. 6 , 19 66 , to Jan. 23 , 19 67 that XXXX was the deceased's physician and that death occurred at 7:10 PM , from causes and on the date stated above.			
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 1-23-67	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, MD.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF Jan. 26. 1967	23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cem. Baltimore Md.	23d. LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR 1. Sanders & Son, North Ave & Broadway, Baltimore		25a. REC'D BY REGISTRAR JAN 25 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00592

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00595

1 PLACE OF DEATH a COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 2 WEEKS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e STREET ADDRESS 14 Rolling Mill Lane	
3 NAME OF DECEASED (Type or print) First MIDDLE Last ROBERT CARL ISAACS		4. DATE OF DEATH Month Day Year January 30 19 67	
5 SEX Male	6 CO. OR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-15-1932
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b KIND OF BUSINESS OR INDUSTRY BASKET FACTORY	11 AGE (In years last birthday) yrs 34
12 CITIZEN OF WHAT COUNTRY? U. S. A.		13 BIRTHPLACE (State or foreign country) NORTH EAST, MD.	
14 FATHER'S NAME LEWIS ISAACS, SR.		15 MOTHER'S MAIDEN NAME EVA LOCKARD	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES KOREA		17 SOCIAL SECURITY NO 7 INFORMANT LEWIS ISAACS, JR.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Artery Embolism DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Popliteal Vein Thrombosis DUE TO (c) Perineal Abscess.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1b)	
20c TIME OF INJURY Month Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty M.D.		22. DATE SIGNED 1/30/67	
EXAMINER'S NAME (Type) Charles S. Petty		23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b DATE THEREOF 2-2-67		23c NAME OF CEMETERY OR CREMATORY NORTH EAST METH.	
23d LOCATION (City or town) (County) (State) NORTH EAST CECIL MD.		24 FUNERAL DIRECTOR GRANT FUNERAL HOME NORTH EAST, MD.	
25a REC'D BY REGISTRAR FEB 1 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00593

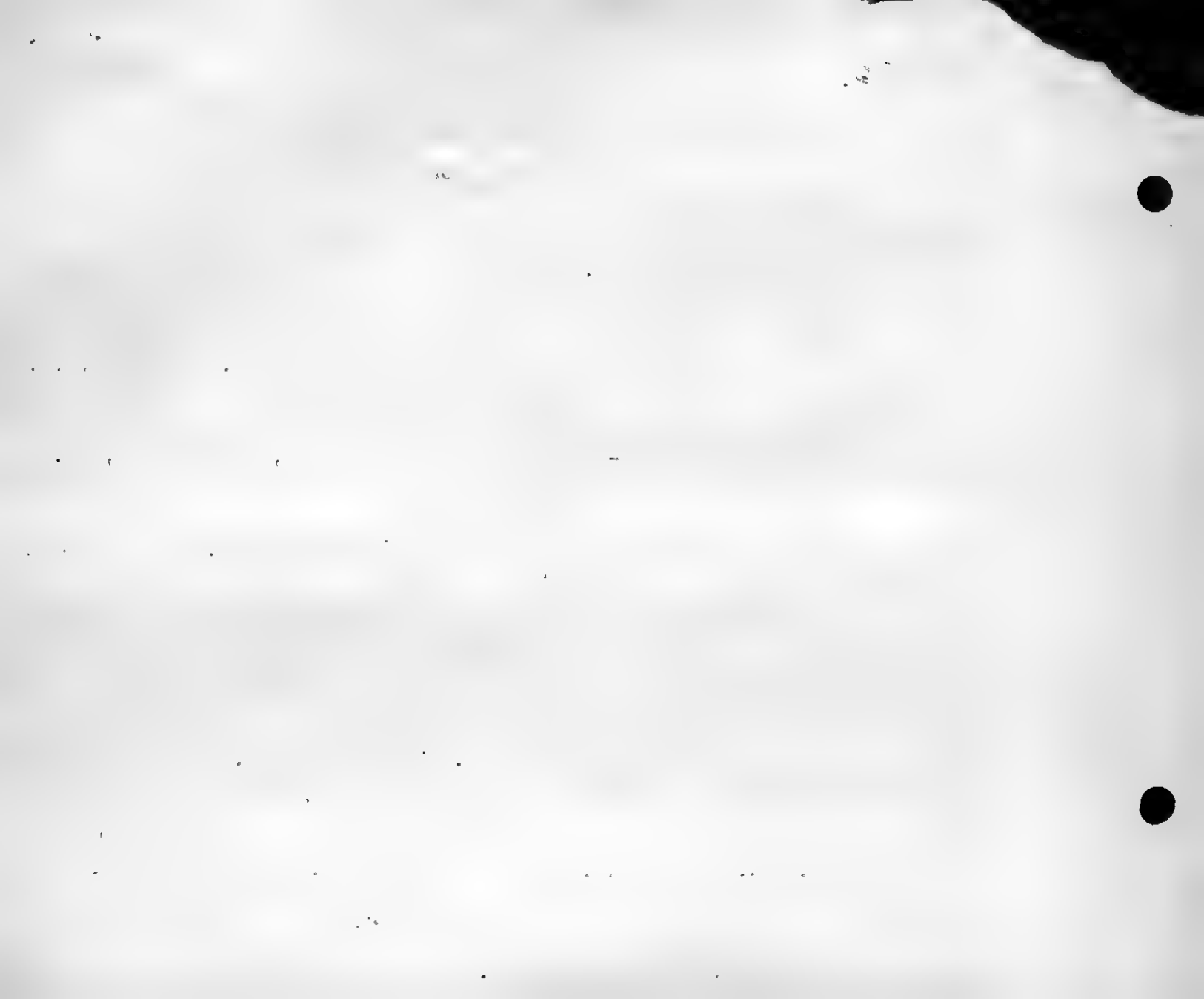
CERTIFICATE OF DEATH

00596

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 15 20 yrs 9 mos	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS 200 Church Street	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH A. KARO		4. DATE OF DEATH Month Day Year January 18 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-12
9. AGE (in years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Northhampton, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Karo		14. MOTHER'S MAIDEN NAME Rose Orban	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO 194-07-7637	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Lobar Pneumonia, Bilateral DUE TO 176A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Carcinoma of Naso-Pharynx with Extension into Base of Skull DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2-3 Wks 6-12 Mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that XXXX (this hospital) attended the deceased from Jan. 23 , 19 46 , to Jan. 18 , 19 67 , and that death occurred at 3:07M , from causes on and on the date stated above.			
22a. SIGNATURE Alfred G. Gillis		22b. DATE SIGNED 1-18-67	
22c. PHYSICIAN'S NAME (Type) Alfred G. Gillis, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Jan. 24, 1967	23c. NAME OF CEMETERY OR CREMATORY Our Lady of Hungarians	23d. LOCATION (City or Town) (County) (State) Northhampton Penna
24. FUNERAL DIRECTOR Swallow Funeral Home, Northhampton, Pa.		25. REC'D BY REGISTRAR JAN 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They should be removed from carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)
20 M 1/66

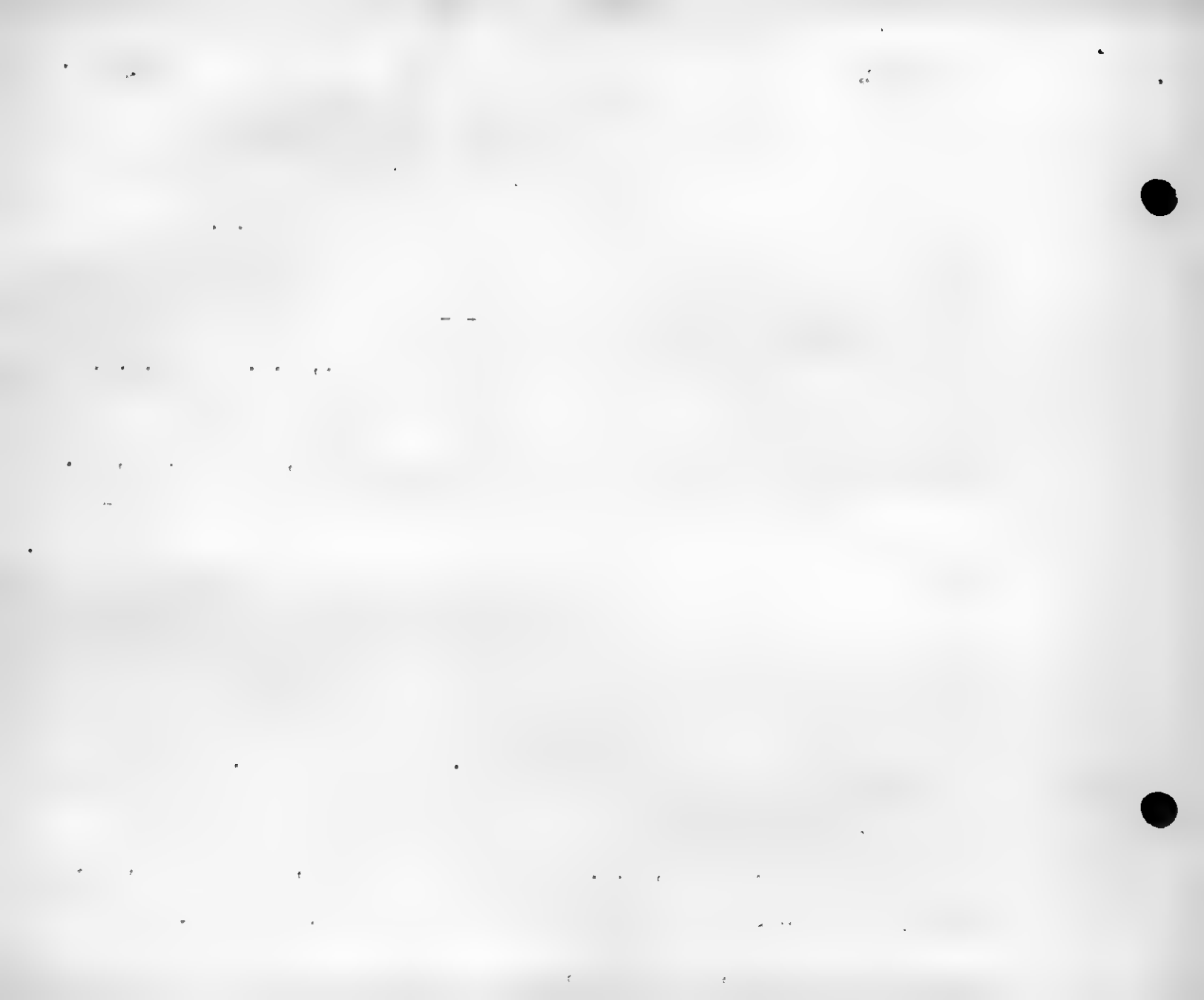
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00594

CERTIFICATE OF DEATH

00597

1 PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 4 mos 19 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1010 P Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES NMI LANG		4 DATE OF DEATH Month Day Year January 3 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-7-00
9. AGE (n years last birthday) 66 yrs		IF UNDER 1 YEAR Months Days 3 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lancaster Co., S.C.	
11 BIRTHPLACE (County & State, or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Ned Lang (D)		14 MOTHER'S MAIDEN NAME Fannie Robinson (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16 SOCIAL SECURITY NO. 577-12-3722	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic carcinoma of left lung DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10-12 days 9-12 mos.		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that JO (this hospital) attended the deceased from Aug. 17, 1966 to Jan. 3, 1967 , that the deceased was born and that death occurred at 12:50 pm from causes and on the date stated above.			
22a. SIGNATURE <i>Joel Blancaflor</i>		22b. DATE SIGNED 1-4-67	
22c. PHYSICIAN'S NAME (Type) JOEL BLANCAFLOR, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 1-9-67	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Ft. Myer, Va.	
24. FUNERAL DIRECTOR Frazier Funeral Home, Washington, DC		25a. REC'D BY REGISTRAR JAN 9 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



00595

CERTIFICATE OF DEATH

00598

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Pa b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CALVERT		c. LENGTH OF STAY IN 1b Oxford	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CALVERT NURSING HOME		e. STREET ADDRESS 29 W. 4th	
3. NAME OF DECEASED (Type or print) FRANCES First R Middle LEE Last		4. DATE OF DEATH Month Jan. Day 13 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 30, 1883
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months 13 Days 19 Hours 67 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reg. Nurse		11b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (County & State, or foreign country) Nottingham P.D. Pa		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Leonard W. Lee		14. MOTHER'S MAIDEN NAME Elysa Tollinger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 198-30-9045	
17. INFORMANT Elizabeth Yerkes		Address Rising Sun, P.D. 2 Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 410.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Heart Di DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov , 19 66 , to Jan , 19 67 that (I) (we) last saw the deceased alive on Jan 12 , 19 67 , and that death occurred at 6:05 PM , from causes and on the date stated above			
22a. SIGNATURE Conrad W. Lenter M.D.		22b. DATE SIGNED Jan 14, 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 17 1967	
23c. NAME OF CEMETERY OR CREMATORY Oxford Cem.		23d. LOCATION (City or Town) (County) (State) Oxford, Chester Co Pa	
24. FUNERAL DIRECTOR RALPH M. REED		25a. REC'D BY REGISTRAR Ralph M Reed - RISING SUN, MD.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JAN 17 1967	

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00596					00599									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY		CECIL			a. STATE		MD							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CHESAPEAKE CITY			b. COUNTY		CECIL							
c. LENGTH OF STAY IN 1b		49 YRS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CHESAPEAKE CITY MD							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?							
NONE					NONE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. AGE (In years last birthday)							
First		Middle		Last		Month		Day						
SOPHIA				LYSAK		1		2						
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8-14-1895		71 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR						
HOUSEWIFE		HOME		UKRAINE		U.S.A.		Months Days Hours Min.						
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
NO INFO					NO INFO									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT				
NO					NONE					PAUL LYSAK CHESAPEAKE CITY MD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY THROMBOSIS										2 HOURS				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?				
										YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Nov. 1966, to Jan 2, 1967, that (I) (we) last saw the deceased alive on Jan 2, 1967, and that death occurred at 3P M. from the causes and on the date stated above.														
22a. SIGNATURE Henry V. Davis M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22b. DATE SIGNED 1/5/67				
22c. PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD										22d. ADDRESS CHESAPEAKE CITY MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE THEREOF 1-7-67				
23c. NAME OF CEMETERY OR CREMATORY ST. ROSE OF LIMA										23d. LOCATION (City, town or county) (State) CHESAPEAKE CITY MD				
24. FUNERAL DIRECTOR Robert L. Pippin PIPPIN FUNERAL HOME										25a. REC'D BY REGISTRAR DATE JAN 5 1967				
25b. REGISTRAR'S SIGNATURE J. Charles Judge														

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00597

CERTIFICATE OF DEATH

00600

1 PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN (b) 8 yrs 2 mos d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2938 E. Fayette Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM B. MARSHALL		4. DATE OF DEATH Month January Day 19 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-98 '95
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship chandler		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Marshall		14. MOTHER'S MAIDEN NAME Frances Parley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 215-12-59394	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Urinary tract infection (acute pyelonephritis, pyonephrosis, cystitis) (c) Bladder stones		INTERVAL BETWEEN ONSET AND DEATH 10-14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that XX (this hospital) attended the deceased from Nov. 3, 1958 to Jan. 19, 1967 and that death occurred at 2:45 M. from causes and on the date stated above.			
22a. SIGNATURE E. E. Folk		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) E. E. FOLK, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Funeral	23b. DATE THEREOF 1/21/67	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR Moran Funeral Home, 3000 East Balto. St.,		25a. REC'D BY REGISTRAR JAN 23 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00598

CERTIFICATE OF DEATH

00601

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Keedysville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 16 3 mos. 24 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS RD # 1	
3. NAME OF DECEASED (Type or print) First THOMAS Middle McAFEE Last McAFEE		4. DATE OF DEATH Month January Day 12 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-96
9. AGE (In years lost birthday) 70 yrs		10. IF UNDER 1 YEAR Months 12 Days 12	11. IF UNDER 24 HRS Hours 12 Min. 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction worker		10b. KIND OF BUSINESS OR INDUSTRY Foxville, Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nathaniel McAfee (D)		14. MOTHER'S MAIDEN NAME Effie Holmes (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 220-09-9268	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma, nasopharynx with invasion of posterior fossa Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that VA (this hospital) attended the deceased from August 17, 1966 to Jan. 12, 19 67 and that death occurred at 10:30 AM from causes and on the date stated above.			
22a. SIGNATURE JOEL BLANCAFLOR, M.D.		22b. DATE SIGNED 1-12-67	
22c. PHYSICIAN'S NAME (Type) JOEL BLANCAFLOR, M.D.		22d. ADDRESS VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 1- 14- 67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr., Bast Funeral Home, Boonsboro, Md.		25a. REC'D BY REGISTRAR J. Charles Judge DATE JAN 17 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Box 1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00599 CERTIFICATE OF DEATH 00602											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East				c. LENGTH OF STAY IN 1b 20 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) No. 8 East Cecil Ave.						d. STREET ADDRESS No. 8 East Cecil Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frank Lewis McCall						4. DATE OF DEATH Month Day Year January 9 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 15, 1906		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Equipment Oper.				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Cecil County, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Daisy McCall					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-14-9461		17. INFORMANT Mrs. Alice E. McCall		Address No. 8 East Cecil Ave North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) <u>Cor Pulmonale</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Cardiac embolus with Aortic</u>								INTERVAL BETWEEN ONSET AND DEATH 5 min 4 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —							
20c. TIME OF INJURY Month, Day, Year Hour a.m. — 19 p.m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) — — —			
21. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> , 19 <u>66</u> to <u>9 Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9 Jan</u> , 19 <u>67</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Klaus H. Huebner</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/9/67</u>			
22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER						22d. ADDRESS NORTH EAST, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/13/67		23c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.			23d. LOCATION (City, town or county) (State) North East Maryland			
24. FUNERAL DIRECTOR Grant Funeral Home <u>Paul R. Crouch</u>						ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR DATE JAN 12 1967		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

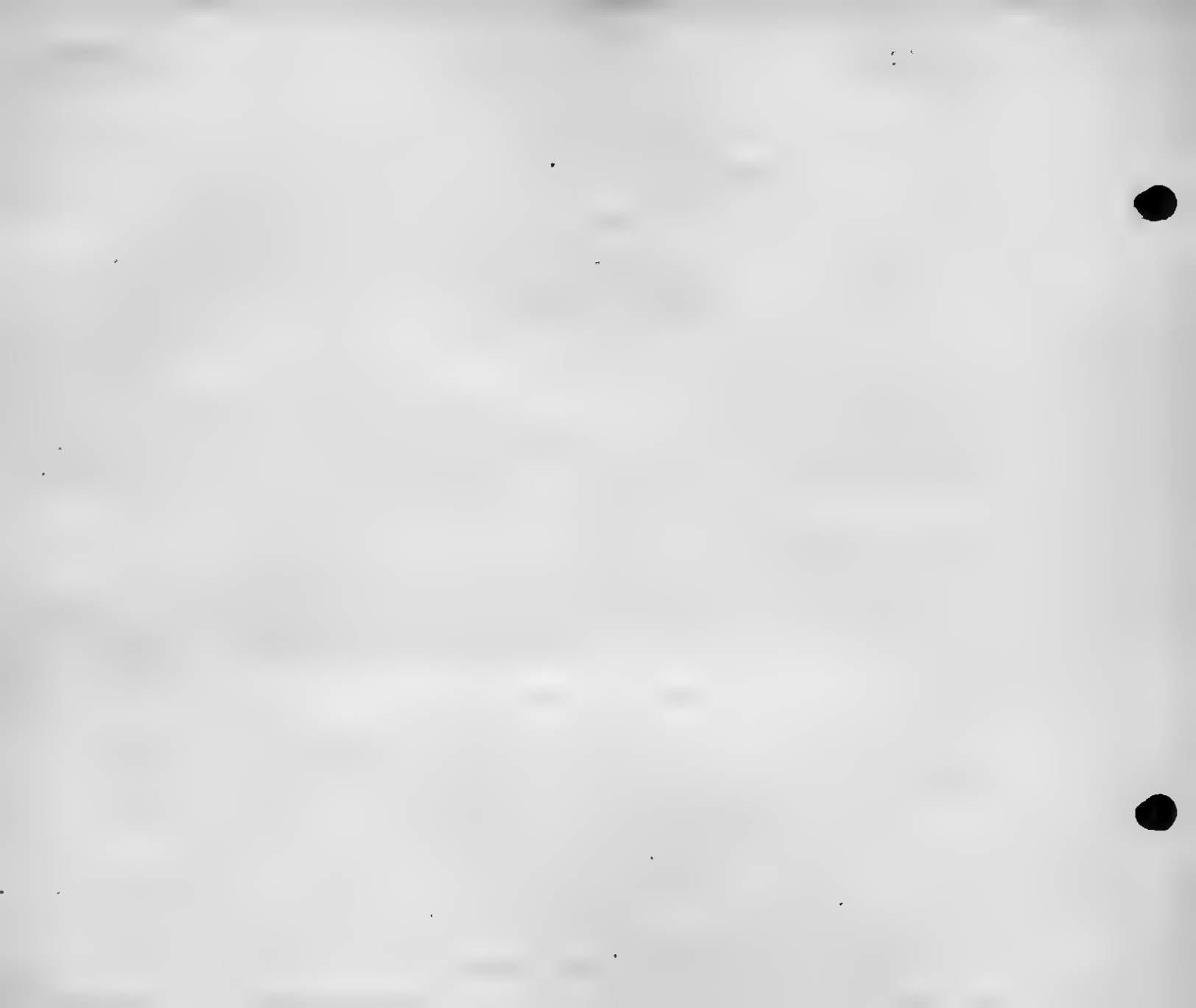
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

00600

00603

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott			
c. LENGTH OF STAY IN 1b 4 wks.				d. STREET ADDRESS Pleasant Hill			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ellicott Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Velma G. McConnell				4. DATE OF DEATH January 21, 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22, 1903	
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY R.H.R. Corp.			
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Russell Gregg				14. MOTHER'S MAIDEN NAME Elizabeth Wilson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 017-21-1138			
17. INFORMANT Charles J. McConnell, Ellicott				Address 3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bowel with Metastases							
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/15/67 to 1/21/67, that (I) (we) last saw the deceased alive on 19 67, and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE John A. Fischer				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) John A. Fischer				22d. ADDRESS ELKTON, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/25/67		23c. NAME OF CEMETERY OR CREMATORY Little Britain Presbyterian Cemetery, Little		23d. LOCATION (City, town or county) (State) Pa	
24. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Nicks				25a. REC'D BY REGISTRAR JAN 30 1967			
25b. REGISTRAR'S SIGNATURE Charles Judge							

MEDICAL CERTIFICATION



00601

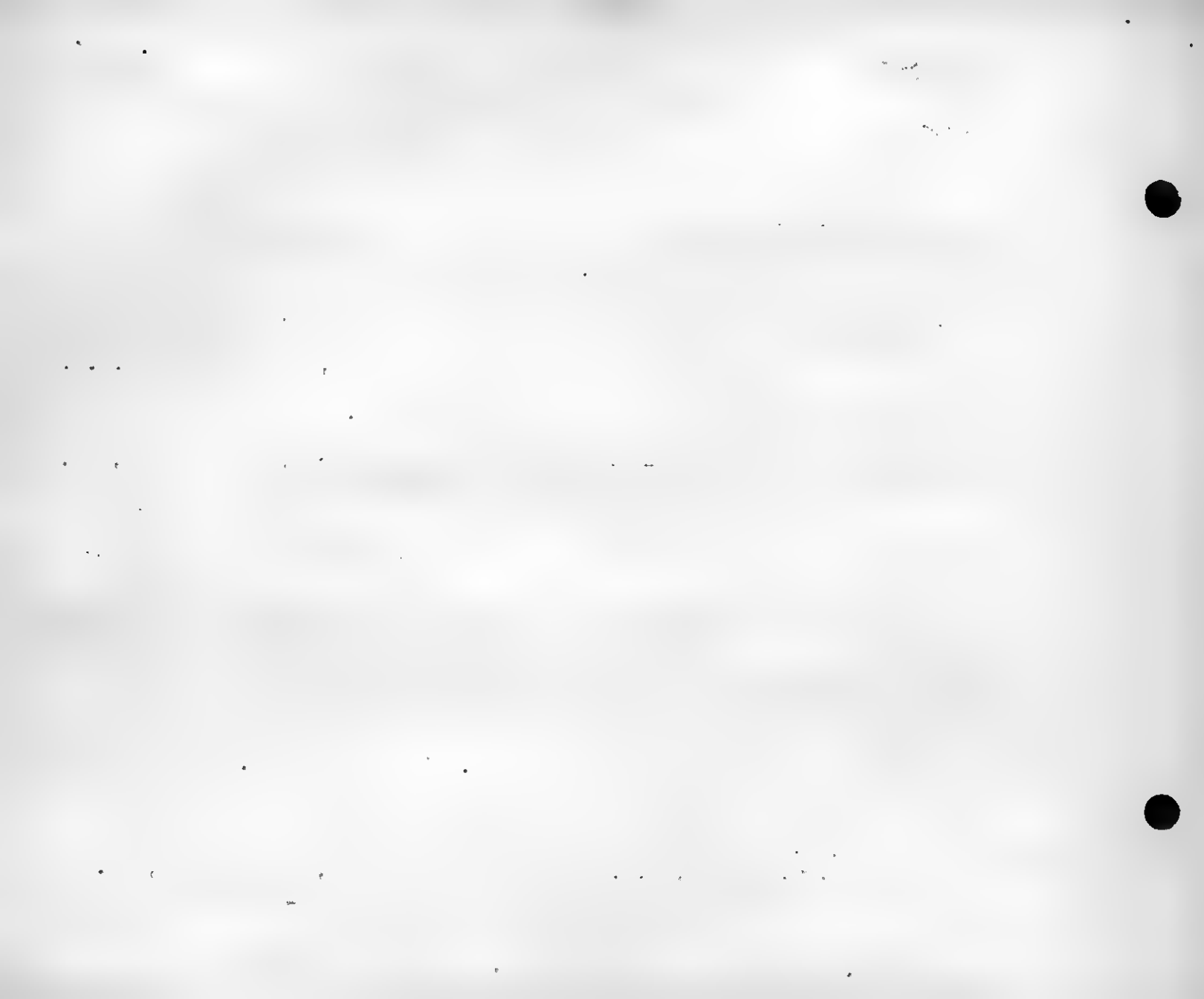
CERTIFICATE OF DEATH

00604

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 83 days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY 1-1-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				e. STREET ADDRESS 104 North Main Street				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLYDE		First G.		Middle McGLOTHLIN		Last McGLOTHLIN		4. DATE OF DEATH Month January Day 17 Year 19 67	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-12-20		9. AGE (In years last birthday) 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Buck County, Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. McGlothlin (D)				14. MOTHER'S MAIDEN NAME Martha D. Jackson (D)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 177-10-9725		17. INFORMANT Address VA Hospital Records, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pleural effusion left 16-51 DUE TO Bronchopneumonia, bilateral w/massive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma of right lung w/widespread metastasis 1-1 1/2 yrs DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 10 days-2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from Oct. 26 , 19 66 , to Jan. 17 , 19 67 and that death occurred at 8:30 AM , from causes and on the date stated above.									
22a. SIGNATURE A. G. Gillis				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-17-67			
22c. PHYSICIAN'S NAME (Type) A. G. GILLIS, M.D.				22d. ADDRESS VA Hospital, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 1/20/1967		23c. NAME OF CEMETERY OR CREMATORY Westbury Cemetery		23d. LOCATION (City or Town) (County) (State) Port Deposit Cecil Md			
24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md.				25a. REC'D BY REGISTRAR JAN 26 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Department of Health, 301 W. Preston Street, Baltimore, Maryland 21201. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00602						00605					
1. PLACE OF DEATH a. COUNTY Cecil						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Penna. b. COUNTY Philadelphia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia					
d. NAME OF HOSPITAL OR INSTITUTION (If none, give street address) R.D. 2						d. STREET ADDRESS 4735 Hazel Ave.					
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD B. McLAUGHLIN						4. DATE OF DEATH Month Day Year Jan. 1 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1901		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker				10b. KIND OF BUSINESS OR INDUSTRY Banking				11. BIRTHPLACE (County & State, or foreign country) Delaware Co. Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward B. McLaughlin						14. MOTHER'S MAIDEN NAME Anna Burns					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war/dates of service) yes WW 2						16. SOCIAL SECURITY NO. 159-07-6873		17. INFORMANT Margaret D. Lipsey		Address R.D. 2 North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4:20 / DUE TO Left ventricular hypertrophy and failure Coronary Atherosclerosis Hypertensive Cardio-Vascular Disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (1) (this hospital) attended the deceased from 10/23, 1966, to 1/1, 1967, that (1) (we) last saw the deceased alive on 28 Dec 1966, and that death occurred at 1:15 PM, from the causes and on the date stated above.											
22a. SIGNATURE Klaus H. Huebner M.D.											
22b. DATE SIGNED 1/1/67											
22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER											
22d. ADDRESS NORTH EAST, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 1/6/67											
23c. NAME OF CEMETERY OR CREMATORY Immaculate Heart Cem.											
23d. LOCATION (City, town or county) (State) Linwood, Del Co. Penna.											
24. FUNERAL DIRECTOR'S SIGNATURE Grant Funeral Home											
25a. REC'D BY REGISTRAR JAN 4 1967											
25b. REGISTRAR'S SIGNATURE James Judge											



ENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.
TO HOSPITAL Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00603					00606					
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital					d. STREET ADDRESS 241 E. Main St.			6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last U. Edward Miller			4. DATE OF DEATH Month Day Year January 3, 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 24, 1901		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY Spitz Lab.		11. BIRTHPLACE (County & State, or foreign country) Penna.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Norman P. Miller					14. MOTHER'S MAIDEN NAME Ella P. Salisbury					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 012-01-0150		17. INFORMANT Mrs. Margaret M. Miller, Elkton, Md.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 445a DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Atherosclerosis DUE TO (c) Hypertensive Cardiovascular Disease									INTERVAL BETWEEN ONSET AND DEATH 6 hours 1 yr 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. — 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec, 1965 to Jan, 1967, that (I) (we) last saw the deceased alive on 8 Jan, 1967, and that death occurred at 12:30 PM, from the causes and on the date stated above.										
22a. SIGNATURE Klaus H. Huebner M.D.					22b. DATE SIGNED 1/8/67			22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER M.D.		
22d. ADDRESS NORTH EAST, Md.										
23a. BURIAL, CREMATION, EMOVAL (Specify) Burial			23b. DATE THEREOF 1/12/67		23c. NAME OF CEMETERY OR CREMATORY Rosebank Cemetery			23d. LOCATION (City, town or county) (State) Calvert, Md.		
24. FUNERAL DIRECTOR Ralph E. Hicks					25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Hicks Home For Funerals, Elkton, Md.					DATE JAN 13 1967			J Charles Judge		

00604

CERTIFICATE OF DEATH

00607

1 PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY (If in hospital, write days, months, and years) 3 yrs 3 mos d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Bel Air c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RD # 2, Box 48 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LUTHER E. QUILLEN		4 DATE OF DEATH Month January Day 17 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-3-28
9. AGE (In years last birthday) 38		10. IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Laborer		10b. KIND OF BUSINESS OR INDUSTRY Air Craft Plant	
11 BIRTHPLACE (County & State or foreign country) Rugby, Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther Quillen (D)		14. MOTHER'S MAIDEN NAME Eula Walton (L)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16 SOCIAL SECURITY NO 1-9-51 to 10-8-52	
17 INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 345X IMMEDIATE CAUSE (a) Aspiration Pneumonia, Recurrent DUE TO (b) MULTIPLE SCLEROSIS DUE TO (c) 10 Years		INTERVAL BETWEEN ONSET AND DEATH 4-7 Days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from May 27, 1963 to Jan. 17, 1967 , and that death occurred at 1:25 am from causes and on the date stated above.			
22a SIGNATURE S. Goldgraben		22b DATE SIGNED 1-18-67	
22c PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 21 Jan. 67	
23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery		23d LOCATION (City or Town) (County) (State) Bel Air, Maryland	
24 FUNERAL DIRECTOR Samuel B. Borge		25a. REC'D BY REGISTRAR JAN 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Tarring Funeral Home, Aberdeen, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MED. EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

00605

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00608

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>NORTHEAST</u>	
c. LENGTH OF STAY IN ID <u>1 DAY</u>		d. STREET ADDRESS <u>211 S. MAIN ST</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>UNION HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>REYNOLDS</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 28 1894</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u> Hours <u>15</u> Min.	11. IF UNDER 24 HRS. Months <u>7</u> Days <u>2</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN BORN'S</u>		14. MOTHER'S MAIDEN NAME <u>WILLIE ANN MILSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-16-9372B</u>	
17. INFORMANT <u>MRS ALBERT SWANSON</u>		Address <u>22 KENT ROAD ELKWOOD EST. ELKTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Just</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL AT HER DOOR, FELL HOUSE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>5</u> p.m. <u>11</u> 19 <u>67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>	20f. (City or town) <u>ELKTON</u> (County) <u>MD</u> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Henry V. Davis</u>		22. DATE SIGNED <u>1/1/67</u>	
EXAMINER'S NAME (Type) <u>HENRY V. DAVIS MD</u>		Address (street, city, town, or county) <u>1000 W. BROADWAY MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Principia Meth. Cem</u>	23d. LOCATION (city, town, or county) (State) <u>Principia-Louise, Md.</u>
24. FUNERAL DIRECTOR <u>Gent Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Paul R. Crouch</u> 25b. REGISTRAR'S SIGNATURE <u>North East, Md.</u>	

CERTIFICATE OF DEATH

00606

00609

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital		d. STREET ADDRESS 317 W. Main Street	
3. NAME OF DECEASED (Type or print) Mary A. Rinehart		4. DATE OF DEATH January 10, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1900
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY --	
10a. FATHER'S NAME George Potts		10b. MOTHER'S MAIDEN NAME Julia Corriden	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12. SOCIAL SECURITY NO. 163-09-1960D	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic Carcinoma, Left Groin			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/5 1967 to 1/16 1967, that (I) (we) last saw the deceased alive on 1/5 1967, and that death occurred at 1:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE John A. Fischer M.D.		22b. DATE SIGNED 1/23/67	
22c. PHYSICIAN'S NAME (Type) John A. Fischer		22d. ADDRESS ELKTON, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/10/67	23c. NAME OF CEMETERY OR CREMATORY Boulden's Chapel Cemetery, Elkton, Cecil, Md.	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks ADDRESS Hicks & Co. Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 30 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00610

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		c. LENGTH OF STAY IN 1b 1 mo. 23 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit Home Corp. Apts.		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15 S. Main Street	
d. STREET ADDRESS Apt. #3, 15 S. Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVERETT WALLACE RUSGROVE Jr.		4. DATE OF DEATH Month January Day 20 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-29-66
9. AGE (In years last birthday) 1-0-23		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Everett W. Rusgrove Sr.	
14. MOTHER'S MAIDEN NAME Nancy Balog		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. None		17. INFORMANT Everett W. Rusgrove Sr. Address 15 S. Main St. Port Deposit, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis (SDII) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D.		22. DATE SIGNED January 20, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		23a. LOCATION (City or town) (County) (State) North East Cecil Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/22/67	23c. NAME OF CEMETERY OR CREMATORY St. Mary Anne's	23d. LOCATION (City or town) (County) (State) North East Cecil Md.
24. FUNERAL DIRECTOR Grant Funeral Home		25a. REC'D BY REGISTRAR Jan 23 1967	
ADDRESS North East, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles S. Springate</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

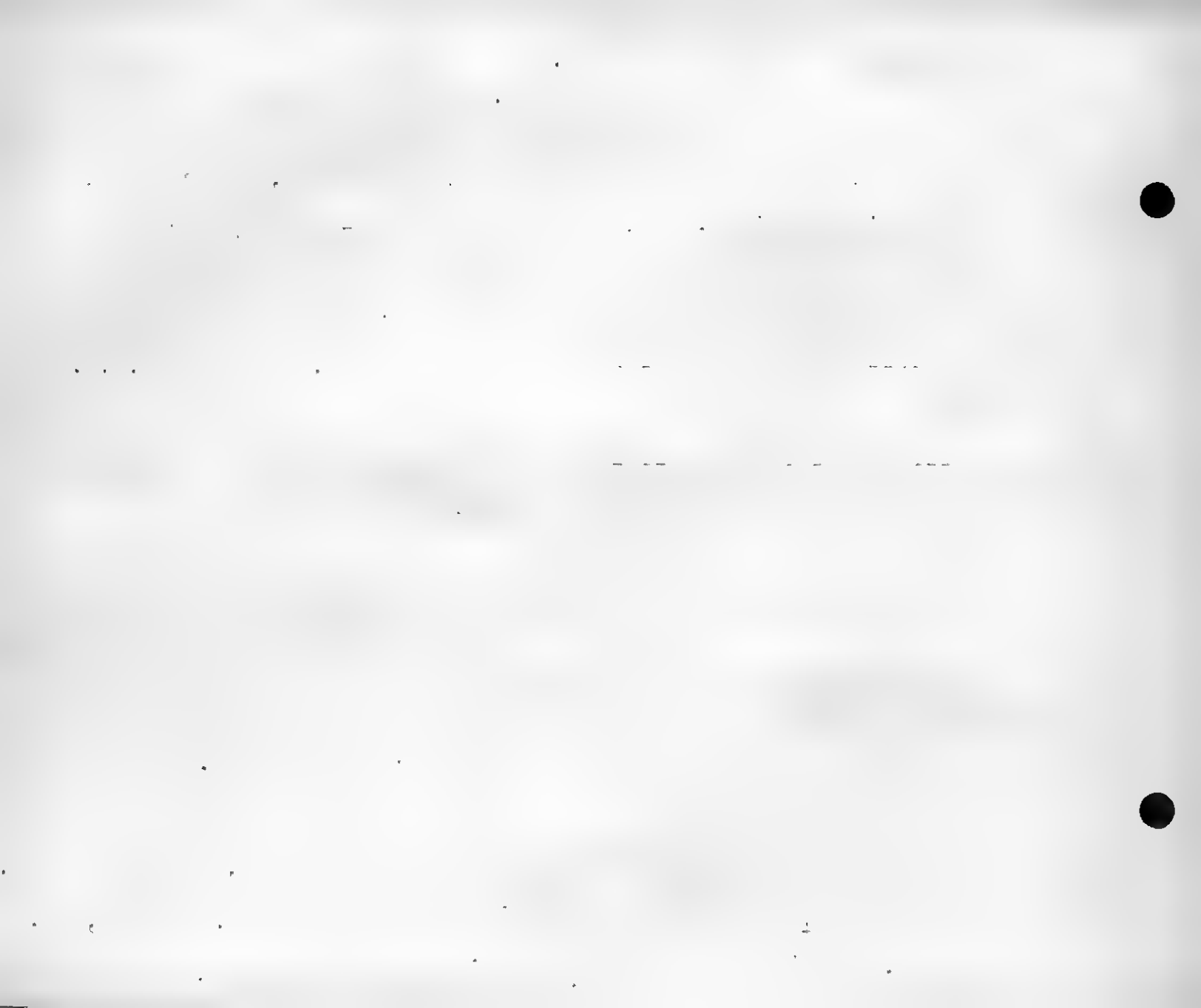
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00608		00611	
1 PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge c. LENGTH OF STAY IN 1b 7 hrs 31 min d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital, USNTC		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Manor Heights d. STREET ADDRESS Apt 233-A Laffey Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last (Not named) SAVAGE		4 DATE OF DEATH Month Day Year January 29 1967	
5 SEX Male	6 COLOR OR RACE Negroid	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years lost birthday) yrs 29 January 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State or foreign country) Cecil County, Maryland U.S.A.
13. FATHER'S NAME HERMAN (n) SAVAGE		14. MOTHER'S MAIDEN NAME ETTIE MAY McCLARY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	17 INFORMANT Hospital Records Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PULMONARY ATELECTASIS DUE TO (b) PREMATURITY DUE TO (c) PREMATURE SEPARATION OF PLACENTA			INTERVAL BETWEEN ONSET AND DEATH HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 29 January 1967 , to 29 Jan., 1967 , that (1) the last saw the deceased alive on 29 January 1967 , and that death occurred at 9:30 AM , from causes and on the date stated above			
22a. SIGNATURE <i>SOL Rockenmacher</i>		22b. DATE SIGNED PM	
22c. PHYSICIAN'S NAME (Type) SOL ROCKENMACHER LT MC USNR		22d. ADDRESS USNTC, Station Hospital, Bainbridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 31 January 1967	23c. NAME OF CEMETERY OR CREMATORY Aberdeen Proving Ground Cemetery	23d. LOCATION (City or Town) (County) (State) Aberdeen, Harford, Md.
24 FUNERAL DIRECTOR LEE A. PATTERSON & SON, Perryville, Md.		25a. REC'D BY REGISTRAR DATE FEB 1 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



CERTIFICATE OF DEATH

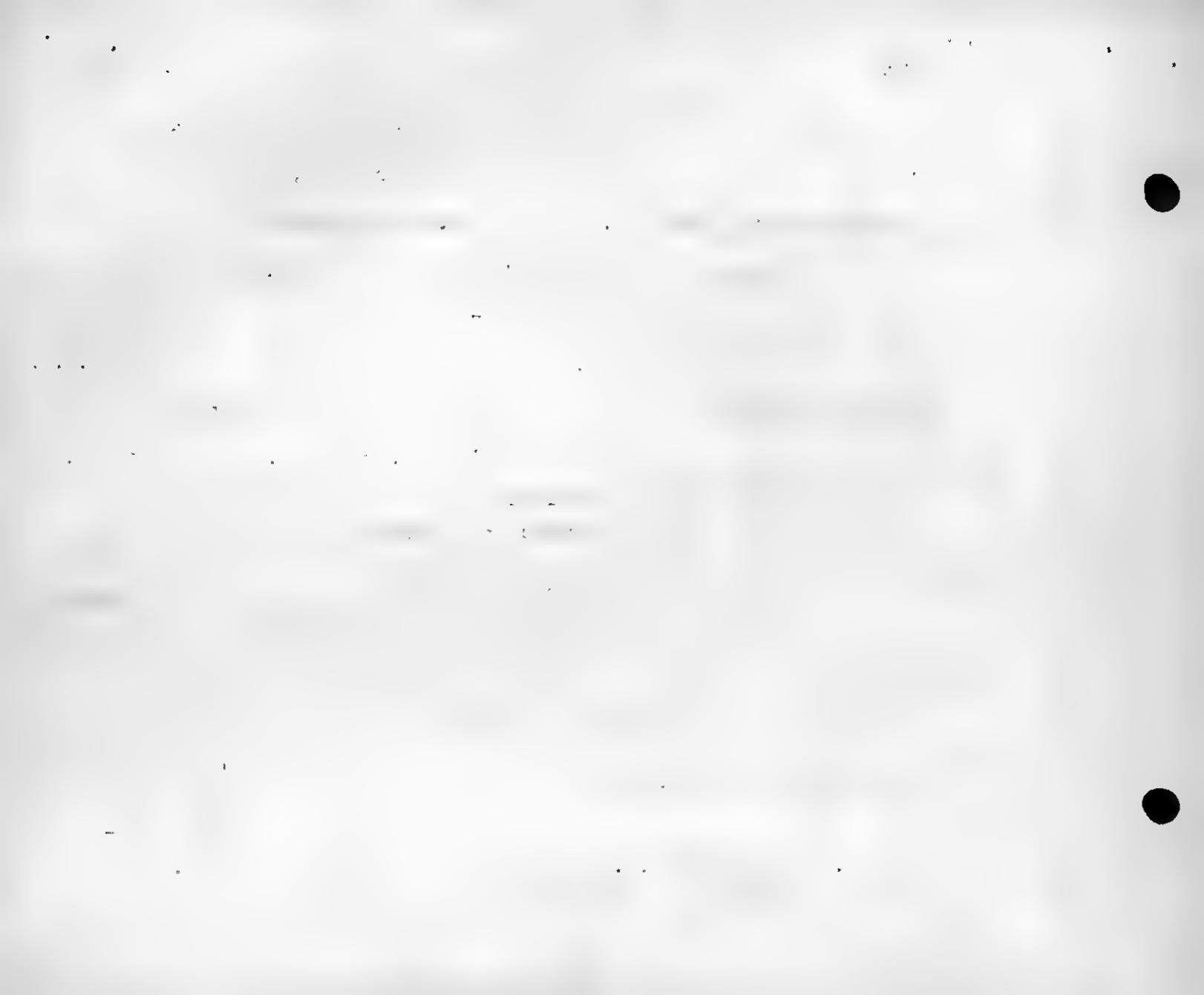
00603

00612

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Perryville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, M	
c. LENGTH OF STAY IN 1b 4 Mo 19 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) V A Hospital, Perry Point, Md.		d. STREET ADDRESS Meadowvale Manor	
3. NAME OF DECEASED (Type or print) First Middle Last CYRUS C SHARP		4. DATE OF DEATH Month Day Year January 17 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-17-90
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY Dental	
11. BIRTHPLACE (County & State or foreign country) Ontario, Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SHARP (Deceased)		14. MOTHER'S MAIDEN NAME Augusta BROWN (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 217-54-7564	
17. INFORMANT Hospital records, VAH., Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Arteriosclerotic heart disease with myocardial fibrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis generalized (c)		INTERVAL BETWEEN ONSET AND DEATH years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 8-29 , 1966, to 1-17- , 1967, that he was last seen alive on 1-17-1967 and that death occurred at 4:00 PM , from causes on and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 1-18-67	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. ADDRESS VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/20/67	
23c. NAME OF CEMETERY OR CREMATORY Angel Hill		23d. LOCATION (City or Town) (County) (State) Havre de Grace Md	
24. FUNERAL DIRECTOR PENNINGTON & SON - Havre de Grace, Md.		25a. REC'D BY REGISTRAR DATE JAN 20 1967	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



00610

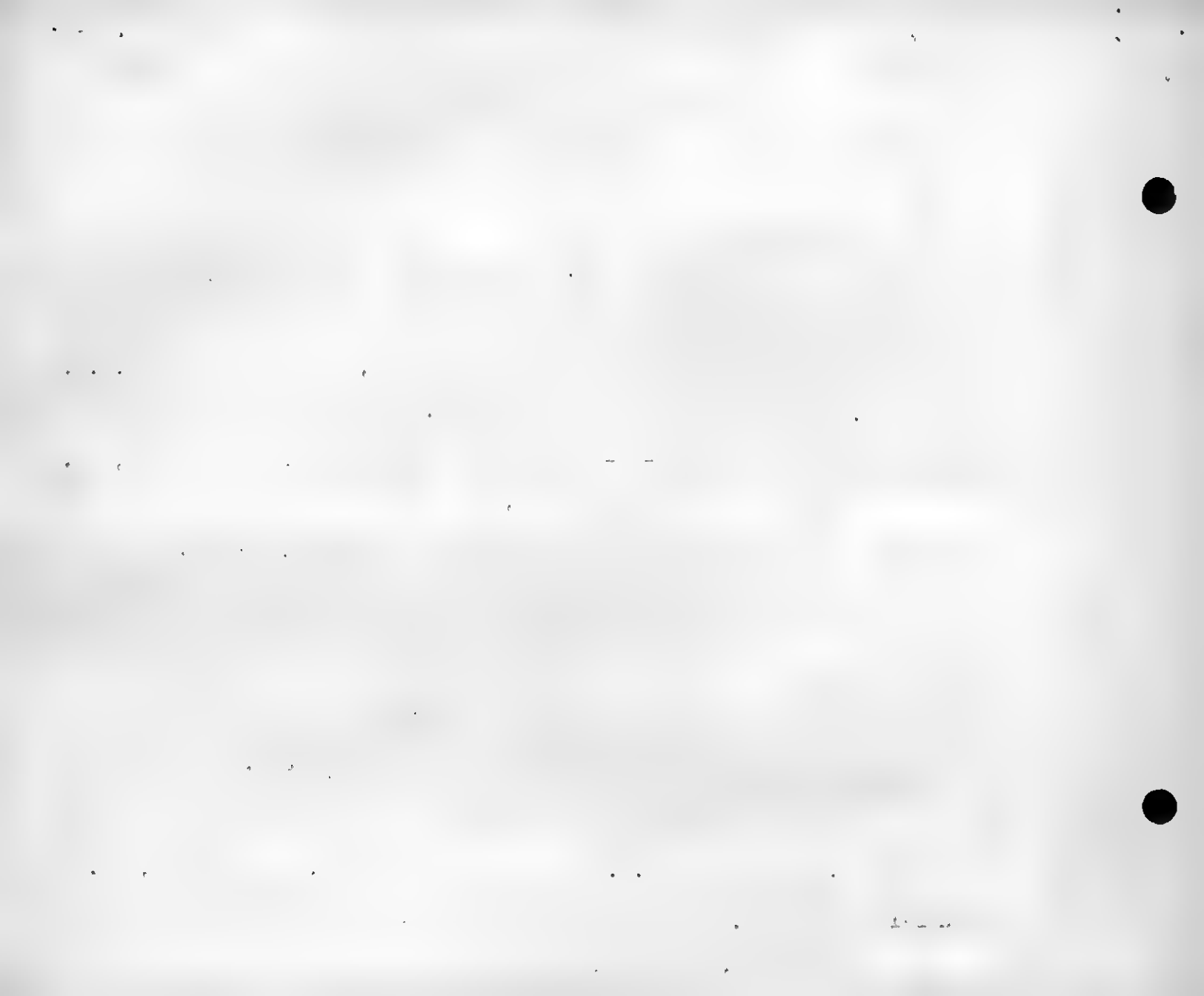
CERTIFICATE OF DEATH

00613

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Hancock			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 16 13 days 5 yr 3 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIS F. SLATTERY				4. DATE OF DEATH Month Day Year January 3 19 67			
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-10-93		9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine		11. BIRTHPLACE (County & State or foreign country) Perryman, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
3. FATHER'S NAME William J. Slattery (D)				14. MOTHER'S MAIDEN NAME Ella Thompson (D)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-03-3029		17. INFORMANT Address VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO left ventricle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute myocardial infarction w/mural thrombus DUE TO Arteriosclerotic heart disease (c) 10-18 days 4-5 years							INTERVAL BETWEEN ONSET AND DEATH 7-10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 20 (this hospital) attended the deceased from July 18, 1961 to Jan. 3, 1967 , that (b)(6)(xx)xxxx saw the deceased alive on xxxxxx and that death occurred at 4:00 M. from causes and on the date stated above							
22a. SIGNATURE S. Goldgraben				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-3-67	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.				22d. ADDRESS VA Hospital, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6 Jan. 67		23c. NAME OF CEMETERY OR CREMATORY Angel Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Havre de Grace, Maryland	
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Maryland				25a. REC'D BY REGISTRAR JAN 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

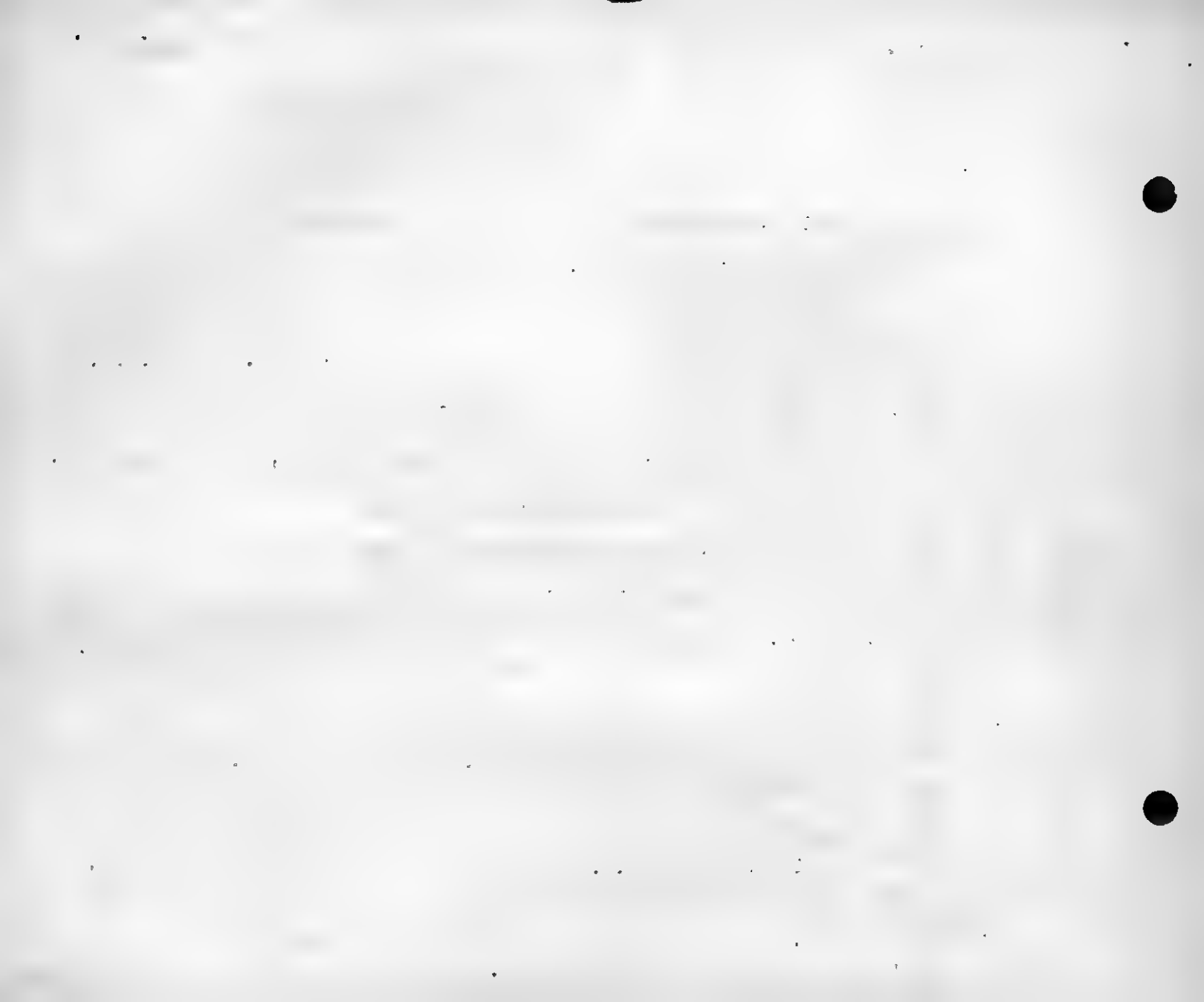
00611

CERTIFICATE OF DEATH

00614

1 PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Havre de Grace</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. LENGTH OF STAY IN 15 <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. STREET ADDRESS <u>321 Strawberry Lane</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>ERNEST W. STOKES</u>		4 DATE OF DEATH Month Day Year <u>January 23 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-4-95</u>
9. AGE (In years last birthday) yrs <u>71</u>		IF UNDER 1 YEAR Months Days Hours Min <u>19 67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer & Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Co.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Rollinsville, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Augustus Stokes (D)</u>		14. MOTHER'S MAIDEN NAME <u>Bertha (?) (D)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I</u>		16 SOCIAL SECURITY NO <u>221-09-8447</u>	
17 INFORMANT <u>VA Hospital Records, Perry Point, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia, Bilateral</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis, Generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>			
19 INTERVAL BETWEEN ONSET AND DEATH <u>4-7 days</u>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>Jan. 18, 1967</u> , to <u>Jan. 23, 1967</u> and that death occurred at <u>12:05 am</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Joaquin R. Garcia, M.D.</u>		22b. DATE SIGNED <u>Jan 23 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joaquin R. Garcia, M.D.</u>		22d. ADDRESS <u>VA Hospital, Perry Point, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial</u>		23b. DATE THEREOF <u>1-26-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Bullock's Mortuary, Havre de Grace, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 27 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only one copy, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 is retained by the hospital or attending physician. ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 is retained by the hospital or attending physician. DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00612		00615	
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN b 4 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Rising Sun d. STREET ADDRESS R.D. 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AXEL IVAR STROMFORS		4. DATE OF DEATH Month January Day 6 Year 1967	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH March 23, 1902 9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 11. BIRTHPLACE (County & State, or foreign country) Finland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sal Stromfors		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 086-01-9773 17. INFORMANT Mrs. Hilja E. Stromfors Address R.D. 1 Rising Sun, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Failure DUE TO Lines & Renal failure Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Ca of Stomach w/ Multiple Metastasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension of H.C.V.D. = Gen. Arth. sclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 min 2 wks 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7... 19... 1960 to 1... 6... 1967 , that (I) (we) last saw the deceased alive on 1... 6... 1967 , and that death occurred at 1... 03 M. from the causes and on the date stated above.			
22a. SIGNATURE Luis M. Cuza 22c. PHYSICIAN'S NAME (Type) Luis M. Cuza		22b. DATE SIGNED 1-7-67 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS North East, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1/8/67		23c. NAME OF CEMETERY OR CREMATORY North East Meth. Cem. 23d. LOCATION (City, town or county) (State) North East, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Grant Funeral Home 24b. ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR 1967 25b. REGISTRAR'S SIGNATURE L. J. Jones	

00613

CERTIFICATE OF DEATH

00616

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm.ssion) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, North East</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS <u>R.D. 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence May Ular</u>				4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Aug. 10, 1875</u>		9. AGE (In years last birthday) <u>91</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Genhart</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>220-46-14934</u>		17. INFORMANT <u>George H. Ular</u>		Address <u>R.D. 2 Box 145 North East, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left cerebral thrombosis with rt. Hemiplegia</u> DUE TO (b) <u>Cerebral Atherosclerosis</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 yr.</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>-</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State) <u>-</u>	
21. I certify that (1) (this hospital) attended the deceased from <u>2 May</u> , 19 <u>67</u> , to <u>28 Jan</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>1/27</u> , 19 <u>67</u> , and that death occurred at <u>7A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Klaus H. Huebner</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>KLAUS H. HUEBNER</u>				22d. ADDRESS <u>NORTH EAST, MARYLAND</u>			
23a. BURIAL OR CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/31/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>North East Methodist</u>		23d. LOCATION (City or Town) (County) (State) <u>North East Cecil Md.</u>	
24. FUNERAL DIRECTOR <u>Grant Funeral Home</u>				25a. REC'D BY REGISTRAR <u>Paul R. Gough</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00614		CERTIFICATE OF DEATH				00617			
1 PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville			c. LENGTH OF STAY IN IB 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Md.					d. STREET ADDRESS 612 North Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MICHAEL Middle G Last VONG					4. DATE OF DEATH Month January Day 23 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-15-96		9. AGE (In years last birthday) yrs 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborem Grocer		10b. KIND OF BUSINESS OR INDUSTRY Delicatessen		11. BIRTHPLACE (County & State, or foreign country) Greece			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE VONG (Deceased)					14. MOTHER'S MAIDEN NAME CONTANTO (Unknown) (Deceased)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 222-01-8096		17. INFORMANT Address Va Hospital records, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of dissecting aneurysm of ascending aorta DUE TO aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan 1 , 19 67 , to Jan. 23 , 19 67 , that (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) and that death occurred at 6:20PM , from causes on the date stated above.									
22a. SIGNATURE S. Goldgraben				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 1-24-67	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.				22d. ADDRESS VAH, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 1/27/67		23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION (City or Town) (County) (State) Elkton Cecil Md.			
24. FUNERAL DIRECTOR H. W. B. du Bouché DUBOSE FUNERAL HOME, Elkton, Maryland				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00615

CERTIFICATE OF DEATH

00618

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 16 Yrs-2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital				d. STREET ADDRESS 506 S Montford Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Joseph Middle A. Last WATROBA				4. DATE OF DEATH Month January Day 8, Year 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12 28 26		9. AGE (In years, most birthday) yrs. 40	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph J. Watroba				14. MOTHER'S MAIDEN NAME Mary J. Posko			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO 219-10-99-80		17. INFORMANT Records Address VA Hospital - Perry Point, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 465X IMMEDIATE CAUSE (a) Undetermined (died in sleep) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Embolism (?) DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____			
21. I certify that 19 (this hospital) attended the deceased from 1 5 51 , 19 a.m. 1 8 67 , and that death occurred at 6:30 M. from causes and on the date stated above.							
22a. SIGNATURE G. A. REYNOLDS		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1-8-67			
22c. PHYSICIAN'S NAME (Type) G. A. REYNOLDS, M.D.		22d. ADDRESS VA Hospital - Perry Point, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) 1/11/67		23b. DATE THEREOF 1/11/67		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Charles Sadowski		1808 Baltimore, Md. Eastern Av		25a. REC'D BY REGISTRAR JAN 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00616

CERTIFICATE OF DEATH

00619

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 3 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Elkton Hospital				d. STREET ADDRESS R.D. 5				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bertha Marie Whitelock				4. DATE OF DEATH Month Day Year January 16, 1967							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 31, 1872		9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick C. Whitelock				14. MOTHER'S MAIDEN NAME Annie Bernard							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT John Davis, Elkton, Md. R.D. 5		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral artery thrombosis</u> DUE TO (b) <u>Arteriosclerosis generalized</u> DUE TO (c) <u>underlying cause last.</u>										INTERVAL BETWEEN ONSET AND DEATH 3 d. many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1-12-1967</u> to <u>1-12-1967</u> , that (I) (we) last saw the deceased alive on <u>1-15-1967</u> , and that death occurred at <u>2:54</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>William D. Johnson</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-10-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>William D. Johnson</u>						22d. ADDRESS <u>123 S. High St., Elkton, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>				23b. DATE THEREOF <u>1/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Elkton, Md.</u>			
24. FUNERAL DIRECTOR <u>Joseph E. Hicks</u>						ADDRESS <u>Hicks Home for Funerals, Elkton, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



00617

CERTIFICATE OF DEATH

00620

1 PLACE OF DEATH a COUNTY <u>Cecil</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>	c LENGTH OF STAY IN Id <u>16 yrs.</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> <u>071</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15 Main Street</u>		d. STREET ADDRESS <u>16 N. Main Street</u>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ada B. Wintermoyer</u>		4. DATE OF DEATH Month Day Year <u>January 4, 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Cau.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/18/1875</u>
9 AGE (In years last birthday) <u>91</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min. <u>4</u> <u>1967</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Vance Whittington</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT Address <u>Robert L. Wintermoyer, Jr., Port Deposit Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Vascular Accident</u> 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-Sclerotic Cordis Vascular Disease</u> DUE TO <u>1892</u> (c) <u>Hypertension</u> <u>1892</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1892</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 3</u> , <u>1962</u> , to <u>1-4</u> , <u>1967</u> , that (I) (we) last saw the deceased alive on <u>1-4</u> , <u>1967</u> , and that death occurred at <u>11:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>G. H. Richards, Jr., M.D.</u>		22b. DATE SIGNED <u>1-5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. H. Richards, Jr., M.D.</u>		22d. ADDRESS <u>Port Deposit, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Shepherdstown, W. Va.</u>
24 FUNERAL DIRECTOR <u>Wm. A. Patterson</u>		ADDRESS <u>Perryville, Md.</u>	25a. REC'D BY REGISTRAR <u>DATE JAN 9 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and they must be filed within 72 hours after death.

00619

CERTIFICATE OF DEATH

00621

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE N.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN lb 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PURLEAR 70.3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LINZIE GREEN Woodie				4. DATE OF DEATH Month Day Year Jan 23 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-2-1881	9. AGE (In years lost birthday) yrs. 85	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (County & State, or foreign country) PURLEAR N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JIMMIE WOODIE				14. MOTHER'S MAIDEN NAME FERBIE WILCOX			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT LINNIE H. WOODIE		Address R.D. #2 ELKTON, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram-negative pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) 493X							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Arteriosclerotic heart disease with poss infarction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 21 Jan , 19 67 , to 23 Jan , 19 67 , that (I) (we) lost the deceased alive on 23 Jan , 19 67 , and that death occurred at 7:00 A.M. from causes on and on the date stated above.							
22a. SIGNATURE Wallace Obenshain				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 23 Jan 67	
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain MD.				22d. ADDRESS Cecilton, Md.			
23a. BURIAL, CREMATION, REMOVAL, etc. BURIAL		23b. DATE THEREOF 1/23/67		23c. NAME OF CEMETERY OR CREMATORY BOIKING SPRINGS		23d. LOCATION (City or Town) (County) (State) PURLEAR N.C.	
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME				25a. REC'D BY REGISTRAR Robert [Signature] ADDRESS ELKTON, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in all other events, within 72 hours after death.

13300

24000

1/23/14

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

00620

CERTIFICATE OF DEATH

00622

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 Wks.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington, Maryland		14-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital Of Cecil County		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frederick William Wright		4. DATE OF DEATH Month 1 Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/82
9. AGE (In years last birthday) yrs. 84		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Labor		10b. KIND OF BUSINESS OR INDUSTRY Labor	
11. BIRTHPLACE (County & State, or foreign country) Essex County Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Wright		14. MOTHER'S MAIDEN NAME Martha Jardin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Leonard Wright		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.1 Acute Cardiac Failure DUE TO (b) Myocarditis DUE TO (c) Gastro-enteritis			INTERVAL BETWEEN ONSET AND DEATH 1-Week 2-Y ears 5- Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 1/11/1967, to 1/28/1967, that (I) (we) last saw the deceased alive on 1/28/1967, and that death occurred at 2:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 1/28/67	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 East High St., Elkton, Cecil, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF Jan. 30, 1967	23c. NAME OF CEMETERY OR CREMATORY Philadelphia, Penna.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME [Signature] Elkton, Md.		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE [Signature]
DATE FEB 3 1967			

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